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## Health Inequalities in Ex-Coalfield/Industrial Communities

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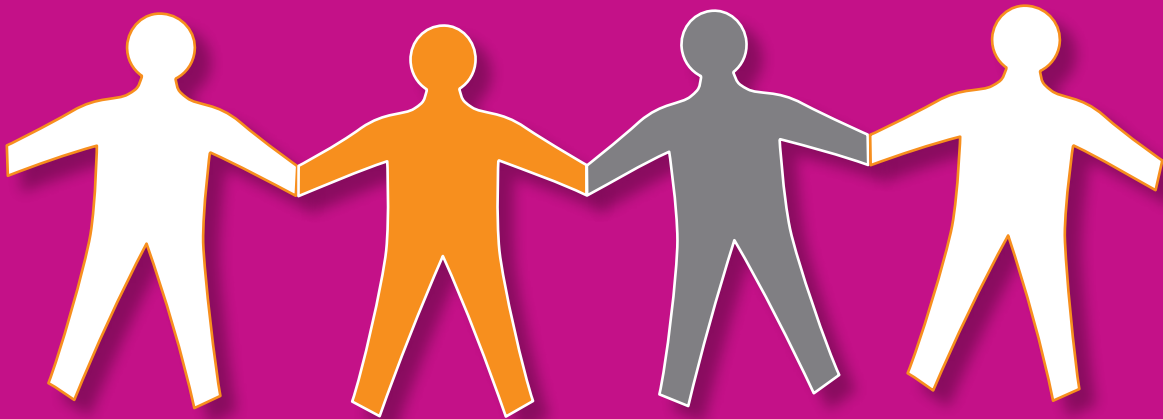
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# Health inequalities in ex-coalfield / industrial communities



This work was undertaken by the IDeA which receives funding from the Department of Health (DH). The views expressed in this publication are those of the authors and not necessarily those of DH.

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## Foreword

### Councillor David Rogers, LGA Community Wellbeing Board Chair

Welcome to this new publication from the Improvement and Development Agency's Healthy Communities Programme.

While the country continues to deal with the recent recession and the impact it has brought on jobs and communities, it seems a fitting time to reflect on the lessons learnt from the experiences of industrial change and decline in ex-coalfield areas in particular, and highlight the range of approaches taken to support the health and wellbeing of local people.

We know that work and health tend to go hand-in-hand, and where large scale job losses have occurred, community morale and aspirations can be affected. But 25 years on, the story around ex-coalfield areas is not all negative. While health inequalities do remain, many areas have re-modelled themselves and much investment has gone into local regeneration. While local government continues to support communities to cope with the current economic difficulties, it is important this progress is not lost. I hope this publication and the examples within it provide some ideas and impetus for action.



## Background on authors

Janet Shucksmith and Sarit Carlebach, from Teesside University, Centre for Health and Social Evaluation (CHASE).

Mylène Riva, Sarah Curtis, David J Hunter, Tim Blackman and Ray Hudson from Durham University, Wolfson Research Institute.

This report is presented by a group of researchers from the Universities of Durham and Teesside. The main research interests of the authors are public health, inequalities, regeneration and coalfields, and partnership working.

The authors are part of a collaborative consortium of the five North East of England universities, the Centre for Translational Research in Public Health (CTRPH).

**Professor Janet Shucksmith** is particularly interested in school and local authority settings as sites for public health improvement work.

**Sarit Carlebach** has research interests in the impact that different communication methods have on reducing health inequalities and improving public health messages.

**Dr Mylene Riva's** research focuses on social inequalities in health and well-being in urban and rural areas, as well as in former and current resource-reliant communities in England and Canada.

**Professor Sarah Curtis's** research focuses on how and why varying geographical settings relate to human health inequalities. She has studied the persistent health disadvantage for older populations brought up in coalfield areas in the 1930s.

**Professor David Hunter's** research focuses on the structure and management of the NHS, and on partnerships in public health and their impact on outcomes.

**Professor Tim Blackman** has experience as a neighbourhood renewal advisor and local improvement advisor, specialising in health improvement. One of his current projects is an investigation of health inequalities across 'Spearhead' areas.

**Professor Ray Hudson** has researched issues of economic restructuring and industrial decline and its human and social costs in North East England and similar regions in Europe and North America.

### Statement on data

At the time of analysis the most recent health data available was for 2007. In April 2009 local authority (LA) boundaries changed. The Office of National Statistics (ONS) has adjusted their reported data to reflect these changes, including their data release in early 2010 for the 2008 health data. These changes have great implications for our report. Several ex-coalfield LA areas (Chester-le-Street, Derwentside, Durham, Easington, and Sedgefield) have been joined together with non-coalfield areas (Wear Valley and Teesdale) to become one Unitary Authority (UA) – Durham. We therefore decided to use the previous data release which covered up to 2007, as the more recent data cannot be attributed to the relevant pre-2009 LA former coalfield areas.

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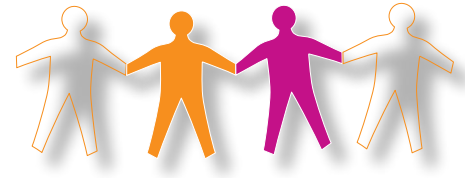
# Introduction

Britain's coalfield areas were once the hub of the nation's economy, but they have experienced a harsh half century of adaptation to very changed circumstances, nationally and globally. Those people who have borne the brunt of the economic shifts have often paid for it not just with their jobs, but also with their health. A type of 'double jeopardy' seems to operate for the populations in former coalfield areas. Occupational disease still affects older people, but problems of unemployment and underemployment have created a range of poor health scenarios in the younger generation too. Attempts to regenerate these areas have often focused on creating jobs and removing the physical detritus of dead industries but have 'overlooked people' (Audit Commission, 2008). Some are now arguing that there has been too much emphasis put on creating replacement jobs and not enough on other issues affecting health. The poor health of the people in the former coalfield areas of England is still clear - even shocking - but there may be new opportunities to address this problem in the broadening of understanding about who has responsibility for delivering good health. We can now see new opportunities for Local Authorities (LAs) and third sector agencies to work together with primary care trusts (PCTs) to improve the health of the local populations of ex-coalfield areas. The IDeA has sponsored discussion around this topic, and has highlighted the possibility of learning from some areas where innovations in partnership working seem to be producing results.

In this document, researchers from Teesside and Durham Universities look at:

- the issue of regeneration of former coalfield areas and ask whether health has been overlooked in the past (section A)
- how we measure progress on health and what we mean by health inequalities (section B)
- current data on health inequalities in the former coalfield areas (section B)
- partnership working at local level and what LAs can do to improve health; and the lessons learned from some selected case studies of single agency and partnership activity on health around the country are discussed (section C)
- debating points and suggestions for ways in which LAs in former coalfield areas might move forward in tackling health inequalities (section D).

The document is targeted at elected members with a health remit, as well as LA and PCT staff with a responsibility for health improvement and reducing health inequalities. The hope is that it will act as a handy reference document on the issue and will also spark debate and discussion about the best way forward.



## Section A Regeneration

Since the first round of major pit closures in the 1960s, coalfield regeneration has been tackled through economic means. The aim was to provide replacement sources of employment by attracting investment in a range of new manufacturing industries. Such jobs, however, were often low waged and low skilled. Over the last 50 or so years there have been successive waves of inward investment, only to be followed by the subsequent closure of plants and job losses as multinational companies closed their 'global outposts' on the former coalfields. It soon became clear that attracting investment by big firms was not necessarily the answer, and the policy emphasis turned more to encouraging the formation and growth of new small firms. However this too produced limited effects in creating new jobs – not least because the depressed state of the former coalfield economies limited the scope and scale of local markets for the goods produced.

As the national economy switched more to service sector employment, this was also reflected in the employment opportunities in former coalfield areas. The establishment of call centres was an example of this wave of regeneration activity, and so were attempts to create new jobs through tourism. But many of the new jobs in call centres proved just as vulnerable to competition from countries abroad as the old manufacturing jobs had been. The prospects for growth in tourism employment on the former coalfields were always limited.

Given the limited success of attempts to regenerate via the formal economy, interest has now turned to the social economy, and more generally the 'third sector', as a source of useful and meaningful work. However, it is too early to judge the extent to which this will provide a more positive solution and one that can be sustained over time. 'Coalfield communities' have considerable potential for positive development – not least because of the traditions of social and economic solidarity and historic resilience of many communities to socio-economic shocks and change – but they continue to face significant challenges that are important for population health.

What has become clear is that attempts at economic regeneration on their own will not always deliver the broader benefits in areas such as health, community cohesion, and the environment. Therefore separate action to tackle the health inequalities associated with the economic decline has

been, and continues to be, needed. An Audit Commission report in 2008 hailed the coalfield regeneration programme as a success story in terms of the growth of new jobs and the huge improvements in the physical environment of these areas, but noted that there are still areas for improvement, stating that 'the focus on physical and economic regeneration has overlooked people' (Audit Commission, 2008).

Poor health is not just the inevitable consequence of industries which carried their own unique risks in terms of accidents and mining-related diseases. It is also the product of a complex mix of factors that has affected the populations of these areas for several generations following the end of mining activity. These areas have suffered from income disparities, from erosion of community identity and structures, and breakdown of social ties because of high in-migration and out-migration. They have suffered from persistently high levels of unemployment and a growing fraction of the community accepts life on Incapacity Benefit as the norm. This has created a situation where young people have low aspirations for the future and the legacy of coal mining decline continues. The health behaviours of men, women and children in these areas are often characterised by so-called 'poor lifestyle choices' around smoking, over-use of alcohol, poor diet and nutrition coupled with inactivity, leading to obesity. Health service provision in these areas has not always been good. There was a transition period when local health authorities had to take over the provision of health services that had previously been provided by the old Coal Boards. But – even where improvements have occurred – people have often been slow to access services, leading to poorer outcomes for their health.

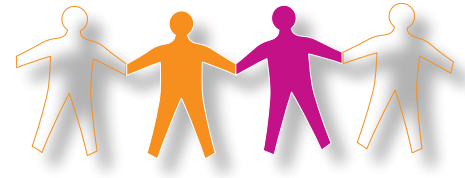
Where new jobs have been created by regeneration activity they have often been an inappropriate match for the skills of existing residents or have been in types of employment characterised by insecurity and low levels of job satisfaction. This in turn has an impact on health and sparks a debate about whether poor jobs are better than no jobs at all, a theme that we will return to later.

This mix of factors has led to poor mental and physical health for many of those living in former coalfield areas. The vicious circle - whereby worklessness and unemployment results in bad health, and bad health contributes to an impoverished and demoralised population - may need to be broken by direct action on a number of fronts. How can improvement in the coalfield areas be thought of in a way that addresses social, economic, environmental and health issues in a coherent way?



## Section A summary: progress on regeneration

- National and global economic forces have ravaged the economies and societies of those coalfield areas which were once the powerhouses of the UK economy
- There have been successive waves of regeneration activity designed to replace lost jobs and to repair the economic and social damage created by industrial decline
- Tackling health inequalities has been lower on the list of priorities than job creation and environmental improvement to date
- Poor health status in former coalfield areas may contribute to the difficulties of social and economic regeneration. There are also social justice arguments for tackling health inequalities
- Health inequalities are not only found amongst older populations directly connected to former heavy or extractive industry. A double jeopardy is at work whereby younger populations are equally badly affected by poor employment opportunities and low expectations
- Direct action to improve community health at a local level is essential – waiting for health improvements to come about as a natural consequence of an economic upturn is unjust and may even contribute to continued poor economic performance.



## Section B

# Health inequalities

### The debate about health inequalities: chasing a moving target?

The Acheson report in 1998 identified priorities for policy development and provided the extra drive needed to take forward government action aimed at addressing health inequalities. Over the last 10 years or so a comprehensive programme of varied initiatives designed to tackle health inequalities have been put in place.

It has also been important for the government to be clearer about the areas where most investment and attention was needed, and to this end the government identified a number of 'Spearhead' areas deriving from the construction of the health inequalities public service agreement (PSA) target. The Spearhead areas are the fifth of LAs in England which have the worst indicators of health and deprivation. Seventy LA areas fall into this category and have been set a PSA target of narrowing the life expectancy gap between themselves and the England population as a whole by 2010. Twenty-three of the 55 former coalfield areas are designated as Spearhead areas.

A government report, **Tackling Health Inequalities 10 Years On** (Department of Health, 2009) recently looked back over the period 1998 to 2008, the decade following the publication of the Acheson report. It concluded that while overall population health had improved, the health gap between social groups remained virtually unchanged. Overall, life expectancy is increasing for both men and women. The rate of premature death (that is, before the age of 75) from all cancers in England and Wales in 2006 showed a fall of more than 18 per cent in 10 years. Early deaths from coronary heart disease have also decreased sharply. Early deaths due to stroke have also fallen markedly – a reduction of 44 per cent in 10 years (Healthcare Commission, 2008).

Despite these very good figures, the Healthcare Commission was guarded in its judgment on progress:

'It is important to note that improvements in health and reductions in inequality take time to achieve. The current picture is very mixed, with good progress overall, but less encouraging news when looking at inequalities. Inequalities in health will continue to be a critical issue for the NHS in the years to come' (pg. 16).

In England, DH has set targets for improving life expectancy and reducing early deaths from the 'big killers'. These targets run to 2010, and the aim is not only to improve the position overall, but also to reduce the impact of deprivation on life expectancy. The differences in life expectancy and rates of death between the fifth of areas with the worst health and deprivation (the 'Spearhead' group) and the population as a whole, are known as 'inequalities gaps'.

The first of these targets (to increase life expectancy at birth in England to 78.6 years for men and 82.5 years for women) is on track. The second, which is to narrow the gap in life expectancy by at least 10 per cent, is not. Although life expectancy in the Spearhead areas is also rising, the rate of increase is slower than in other parts of the country and the gap between these areas and the average for the England population as a whole is widening.

The targets on the 'big killers' of circulatory disease and cancer give rise to some optimism. The overall target for deaths from circulatory diseases, a 40 per cent average reduction, has already been met. The target for reducing the inequalities gap by 40 per cent has almost been met, but the direction of travel on this target has not been consistent over the years.

The target for cancer, a decrease of at least 20 per cent in the overall death rate, is on track to be met if current trends continue. The absolute gap has narrowed, but the relative gap has increased from 15 per cent in 1995-1997 to 16 per cent in 2005-2007.

The target for infant mortality is to reduce, by at least 10 per cent, the gap in mortality between people in the 'routine and manual' group and the population as a whole. This gap has widened since the period 1997-1999. However, there has been a narrowing of the gap since 2002-2004. The infant mortality rate for the population as a whole in 2005-2007 was 4.7 deaths per 1,000 live births, and the rate for those in the routine and manual group was 5.4 deaths per 1,000. The gap in infant mortality across socio-economic groups is now starting to close and if it continues to narrow at the rate observed since 2002-2004 the infant mortality element of the target will be met.

So although general progress has been good, the path of travel in terms of reducing inequalities is frustratingly bumpy. The concept of health inequalities is clearly a complex one since it is – in many ways – a measure of 'top against bottom' in terms of achievements in health. So although progress has been made in raising life expectancy for the population as a whole, the fact that some groups make progress faster than others actually extends the gap between

those with the best health and those with the poorest, making the target a moving one. For example, despite the progress generally on health, the life expectancy gap between the Spearhead areas as a group and the country as a whole has widened over the last 10 years by 4 per cent for males and 11 per cent for females. So although health overall has improved in the Spearhead areas, it has improved faster elsewhere. As the **Ten Years On** review notes:

“The drive for health improvement can produce an ‘inverse care law’ effect where the benefits of such programmes accrue to the more advantaged groups who have awareness and knowledge of how to use the system. In addition, the reach of public services can be weaker in disadvantaged areas and less able to counteract this effect. The result is that overall improvements in health can mask continuing inequalities (DH, 2008, p. 14)”

Given these ‘moving target’ problems, there has been some debate about the value of this Spearhead designation. However Department of Health figures (2005-2007) indicate that 47 per cent of Spearhead areas are on track by 2010 to narrow the ‘gap’ in life expectancy by 10 per cent in their areas compared with England, calculated using 1995-1997 baselines for either males or females or both (Secretary of State for Health, 2009). This is an improvement on 2004-2006 where data showed that only 41 per cent were on track. The Healthcare Commission report, *State of Healthcare 2008*, cites evidence that Spearhead areas perform better with regard to health improvement than non-Spearhead areas. So, while the targets are tough ones, having the focus and the additional resources that accrue from the ‘Spearhead’ designation may be having real impact.

Spearhead areas are now being encouraged to meet their challenging targets with help from DH national support teams. Using a peer review model and careful analysis of local data, teams of experts are invited into local areas to help examine local public health targets and ways of achieving them. Such measures enable tailored local actions to meet the specific problems of the context.

Despite these and other initiatives, progress has been uneven and generally poor. In view of this, the government established an independent strategic review of health inequalities at the end of 2008 to inform policy post-2010. Chaired by Professor Sir Michael Marmot, who chaired the global Commission on Social Determinants of Health (WHO, 2008), its final report was published in February 2010.

In the next section we review what the latest data tell us about inequalities and their specific impact on the health and wellbeing of people in the coalfield areas.

## Regeneration and health on the former coalfield areas

In this section we aim to show how socio-economic and health conditions in the former coalfield areas compare with the country as a whole and how their relative position has changed over recent years. We also examine the diversity among coalfield areas. We report the results of analysing data for the 55 English coalfield LA areas defined by the Coalfield Regeneration Trust as former coalfield sites. These are each compared with the LAs in England overall. These LA areas correspond to those preceding the most recent boundary changes in April 2009.

### Socio-economic context

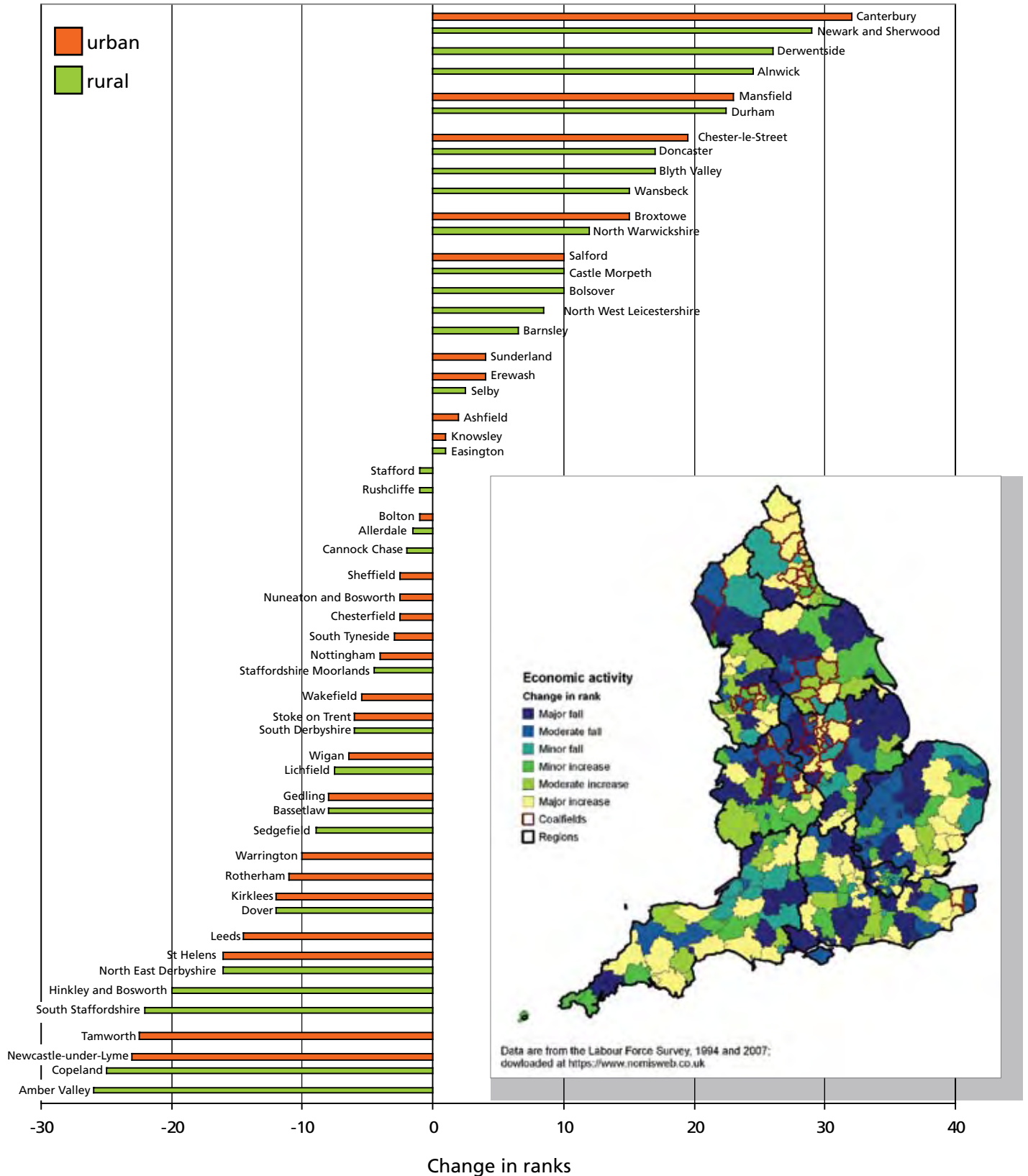
The conditions in LAs on former coalfield areas were described using four sets of information:

- **changes in employment** between 1994 and 2007
- **changes in economic activity rate** between 1994 and 2007 (see note 1)
- **deprivation levels** for 2007
- **the proportion of people claiming benefits** (Job Seekers’ Allowance (JSA) and National Insurance Credits) between 2007 and 2009.

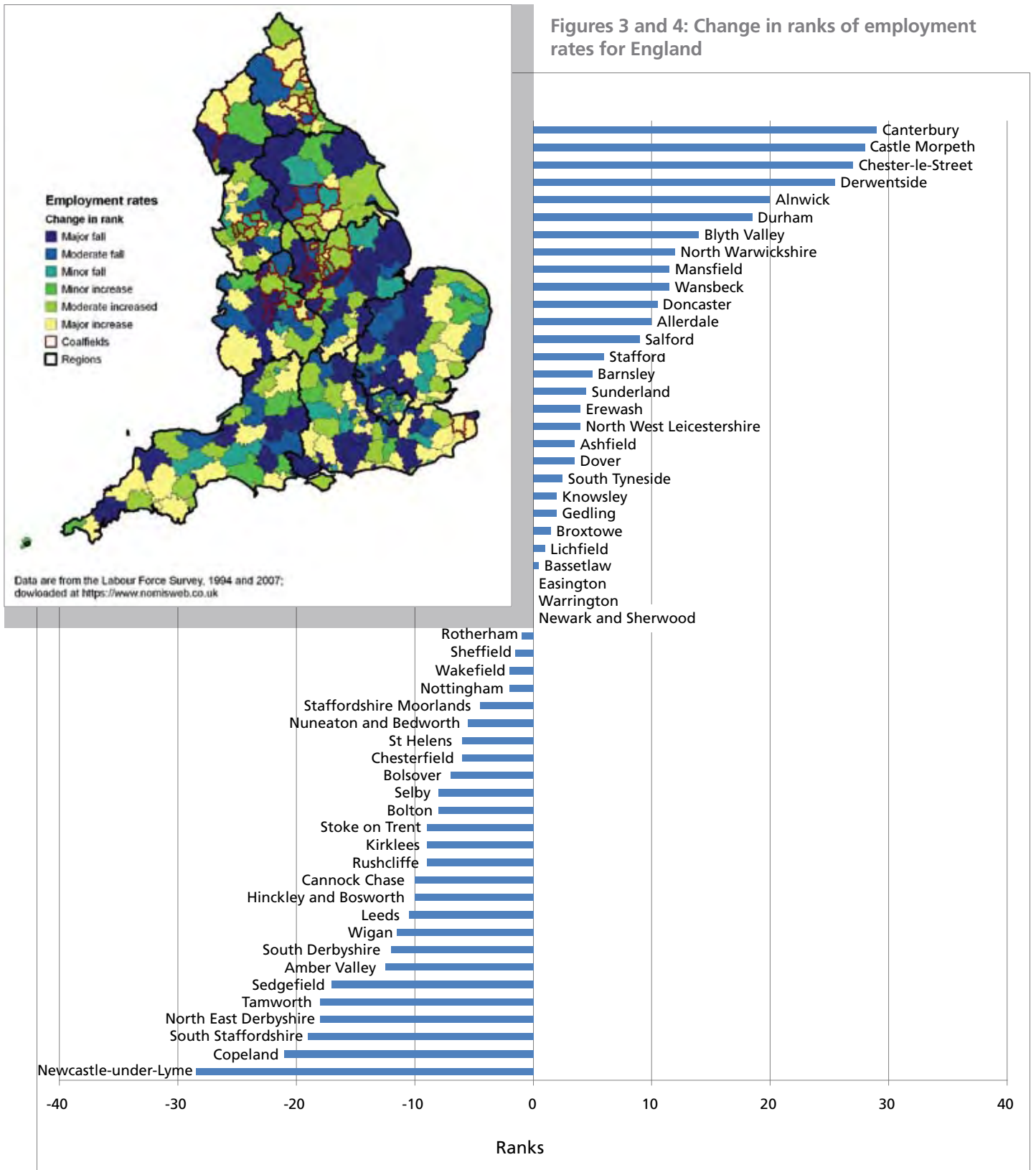
The economic activity and employment rates of all LAs in England, including former coalfield areas, were ranked and then compared for change in their ranking (rank 2007 minus rank 1994). Districts which have seen their economic activity and employment rates increase over the period will be ranked higher, whereas those with declining economic activity and employment rates will be ranked lower (see note 2). The results are presented in Figures 1 to 4. They show that between the two periods there is a fair amount of variability in economic activity and employment rates across the coalfield areas.



Figures 1 and 2: Change in ranks of economic activity for England



Figures 3 and 4: Change in ranks of employment rates for England





The results show that 32 coalfield areas have experienced a decrease in rank where economic activity is concerned, (i.e. a decline in economic activity), whereas 23 have seen an improvement in their economic activity rank. Breaking the results down further and looking at the differences between urban and rural areas (figure 2) shows that about 65 per cent of coalfields located in urban areas have seen their rank decrease between 1994 and 2007, whereas about 52 per cent of rural coalfields have decreased in rank (see note 3). So urban coalfield areas would therefore appear to have fared worse than rural coalfield areas.

Although many of the coalfield areas in the North East, South Yorkshire and the East Midlands show improvement in their ranking in relation to both economic activity and employment, areas in the North West and in the West Midlands show relative falls in the level of economic activity. This underlines the point made earlier about the differential response to economic regeneration opportunities in the former coalfield areas. In other words, it is not easy to simply lump all the former coalfield areas together and see them as having the same fate or fortunes.

### Deprivation

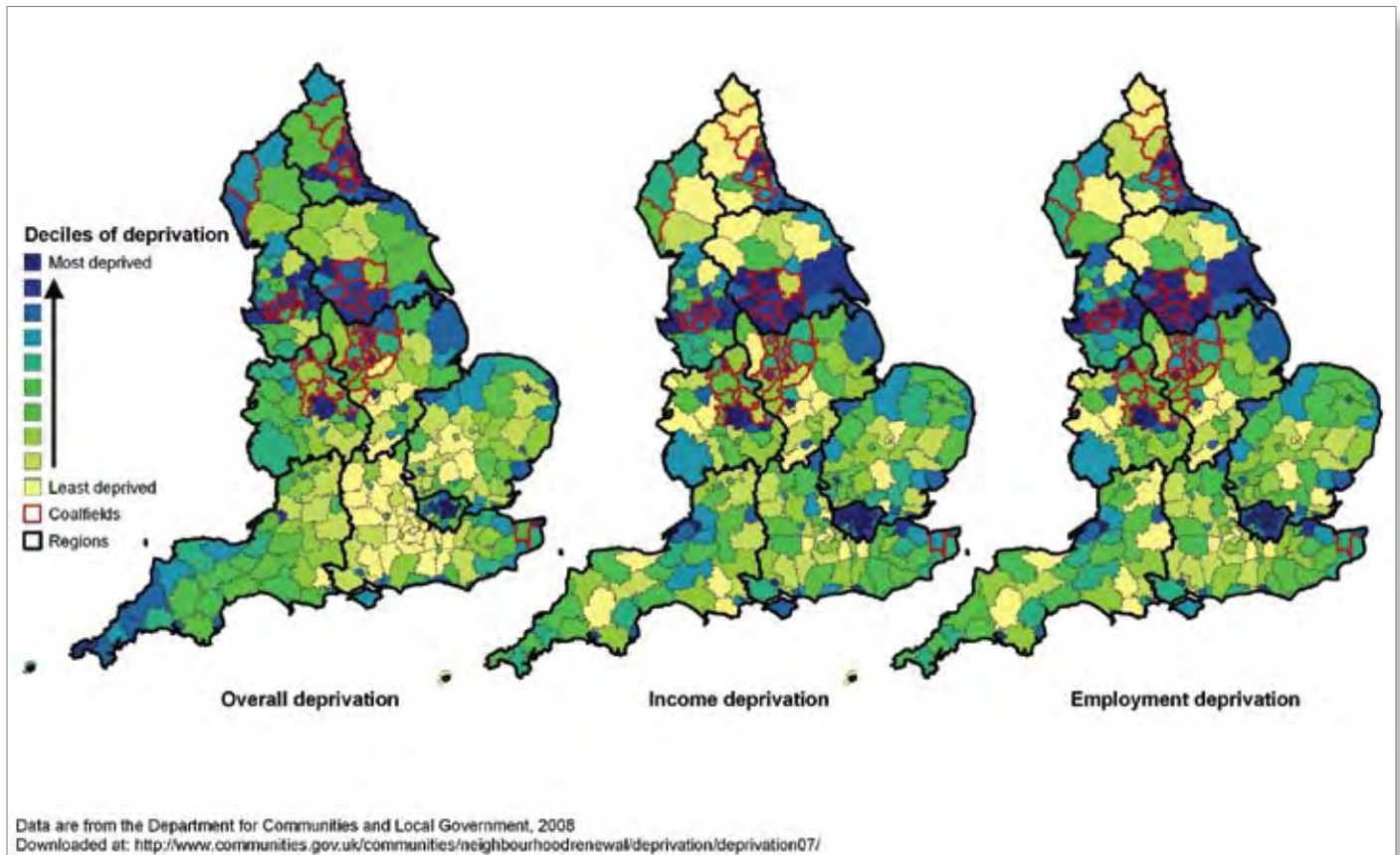
Despite relative increases in economic activity and employment over the period, deprivation is still an issue in former coalfield areas. Even within areas, there are significant differences in local levels of deprivation and variability amongst individual people which we can show if we conduct the analysis at an even finer level such as Lower Super Output Areas.

A significant number of the new jobs created through regeneration activity may have been taken by 'new' residents, that is, by workers having moved into the area for work and not by 'original' residents. Indeed, the Audit Commission report notes that over a third of the jobs created between 1998 and 2006 went to people who had moved into these areas to work (Audit Commission, 2008).

Figure 5 shows deciles (equal number of LAs in ten groups) of overall deprivation, income deprivation and employment deprivation from the 2007 Index of Multiple Deprivation (see note 4). It is clear that coalfield areas remain amongst the most deprived parts of England. Although there appears to be variation in the extent of deprivation levels between ex-coalfield areas, **overall deprivation** and **employment deprivation** are significantly higher in former coalfield areas than the average for all districts of England. However, levels of income **deprivation** are not significantly different between coalfields and other areas in England.



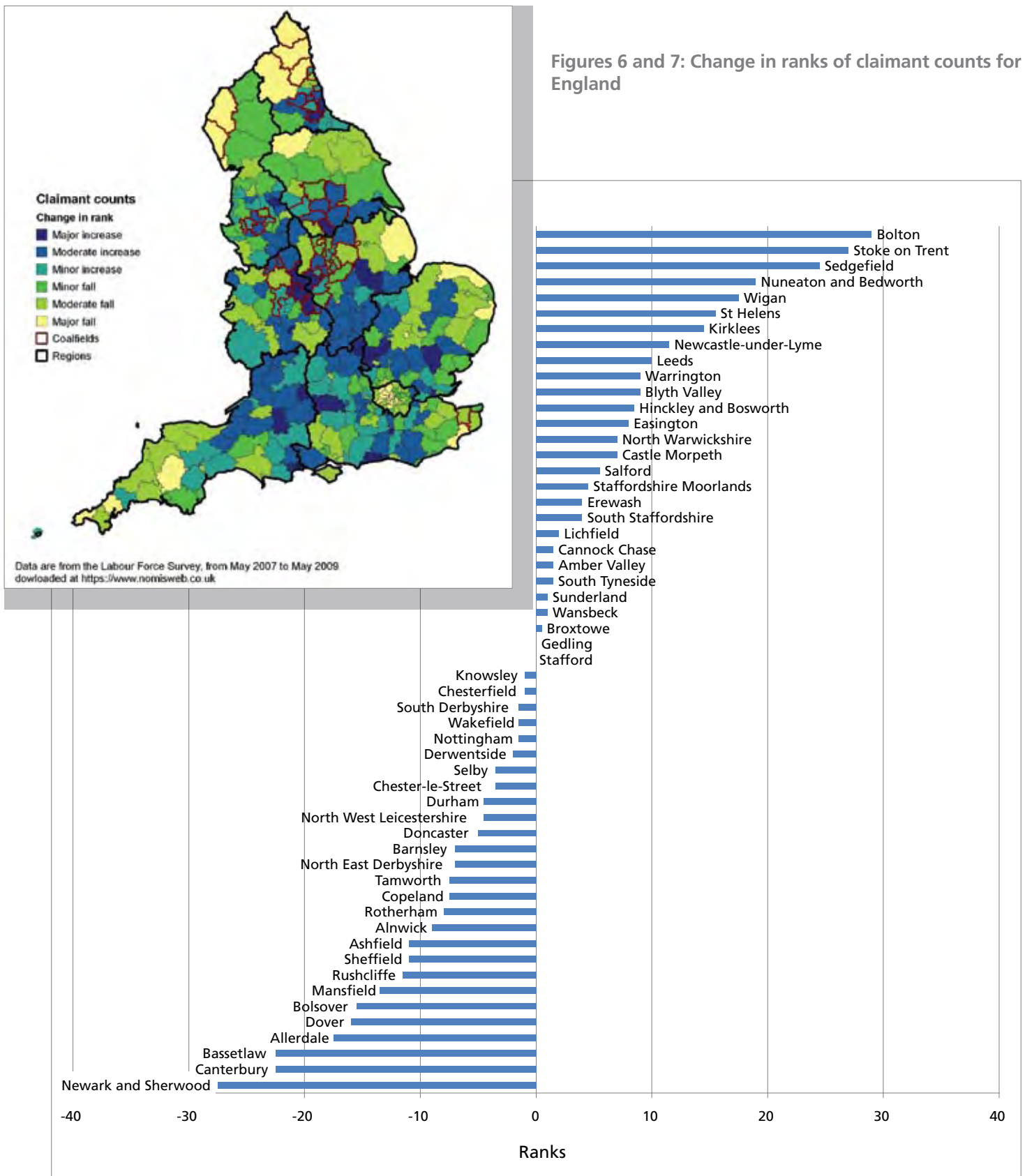
Figure 5: Change in ranks of economic activity for England



Another way of measuring deprivation is by looking at the proportion of people claiming Job Seeker's Allowance (see note 5). To compare how the proportion of claimants has changed between 2007 and 2009, districts were ranked and compared between time periods, following the same approach described above for economic activity and employment rates. Figure 6 shows the change in ranks of JSA claimant counts at the LA level for coalfield areas and for the rest of England (see figure 7 for the increase and fall in national ranks for the 55 coalfield areas). Between 2007 and 2009 it appears that, on the whole, coalfield areas have risen up the ranks in terms of proportion of claimants, indicating that the relative position of the coalfield areas in terms of proportion of claimants, compared to the rest of England, is worse now than it was in 2007. However, some coalfields located in the North East and North West, as well as in the East Midlands, have gone down (improved) in the ranking for unemployment.



Figures 6 and 7: Change in ranks of claimant counts for England





### **Health outcomes on the ex-coalfield areas**

What then is the association with health outcomes of these patterns of economic regeneration and activity and deprivation levels?

The profiles of LAs presented here were derived by the research team, using several indicators:

- Standardised mortality ratios for the whole population for the years 2005-2007 (see note 6).
- Disease specific standardised mortality ratios for the years 2005-2007
- Changes in standardised mortality ratios between 1994 and 2007

Most of the former coalfield areas are characterised by higher rates of mortality than the average for all districts of England (figure 8). These rates are indeed higher when considering deaths for the whole population and when focusing on early mortality as calculated by deaths for people under the age of 75 years.

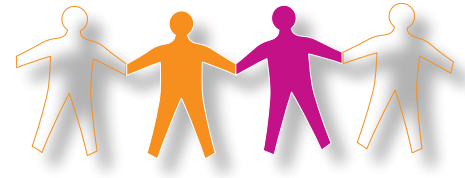
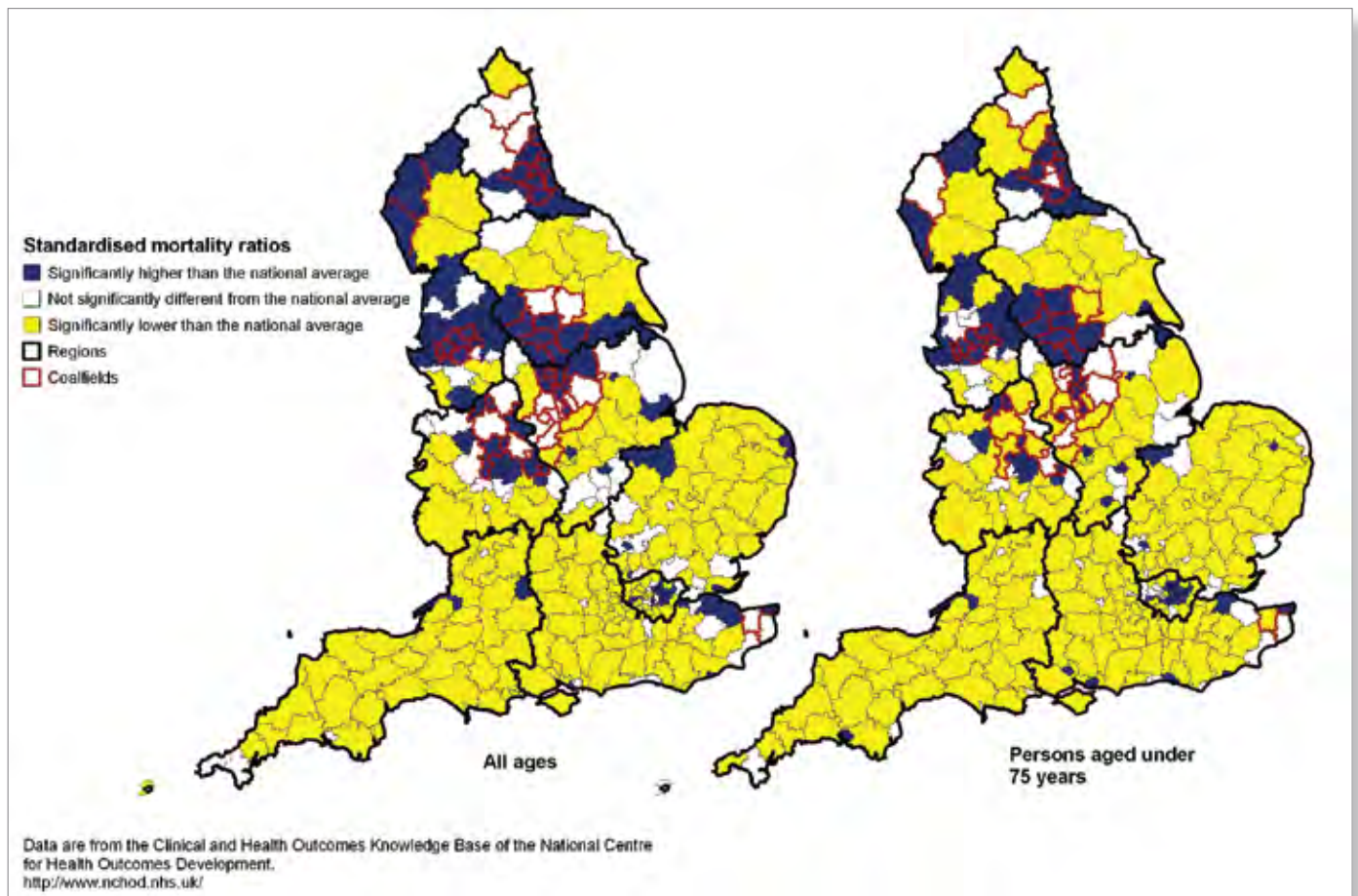


Figure 8: All cause standardised mortality ratios for all ages and for persons aged under 75 years



The picture for the former coalfield areas gets bleaker when looking at the changes in standardised mortality ratio (SMR) over time (figure 9). A value of 100 corresponds to the national average mortality level, taking account of sex and age composition of areas. A value above 100 therefore shows a higher (worse) level of mortality compared to the national average, whereas values lower than 100 indicate a lower (better) than average mortality. As can be seen, mortality ratios in former coalfield areas have increased over the period 1994 to 2007, whereas those in other districts have decreased slightly, showing that inequalities between coalfield areas and other LAs in England have increased because coalfield populations have lagged behind other parts of the country in terms of reduction in mortality.

When the SMRs are broken down into the major causes of mortality (cancer, coronary heart disease and stroke) most of the coalfield areas have rates that are above the national average (figure 10). Though there have been many improvements across the country, including in the former coalfield areas, these improvements have not been as great and have meant that they continue to lag behind other areas of England. When looking at premature mortality (under 75 years), many areas are managing to close the gap and have mortality rates which are similar to or better than the national average (figure 11). This is particularly noticeable when looking at deaths caused by stroke.



**Figure 9: Standardised mortality ratios (SMR; population weighted average) for former Local Authority Districts (LADs)**

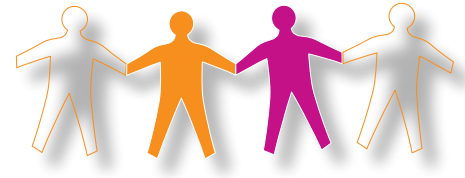


Figure 10: Standardised mortality ratios for all age groups (2005–2007)

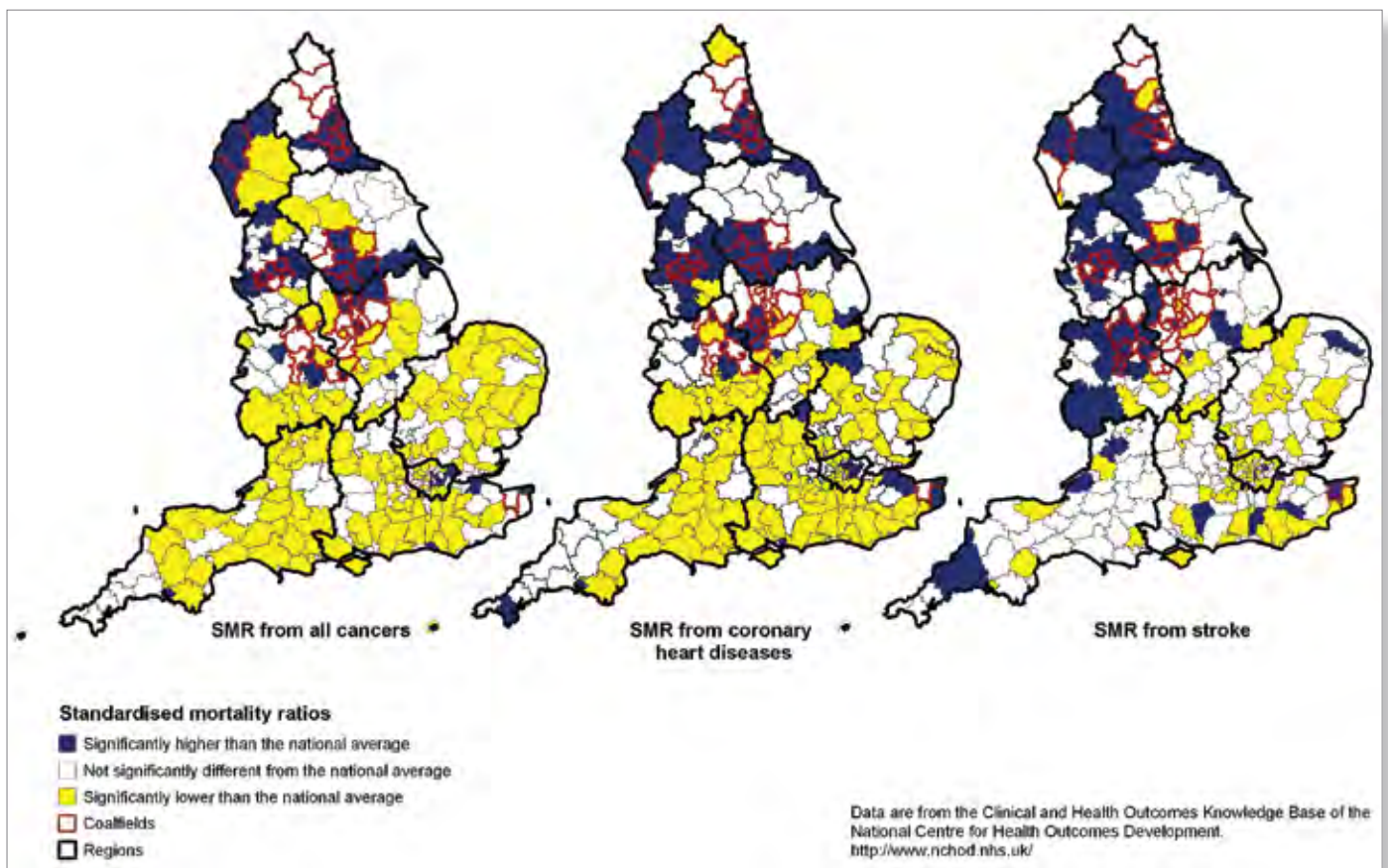
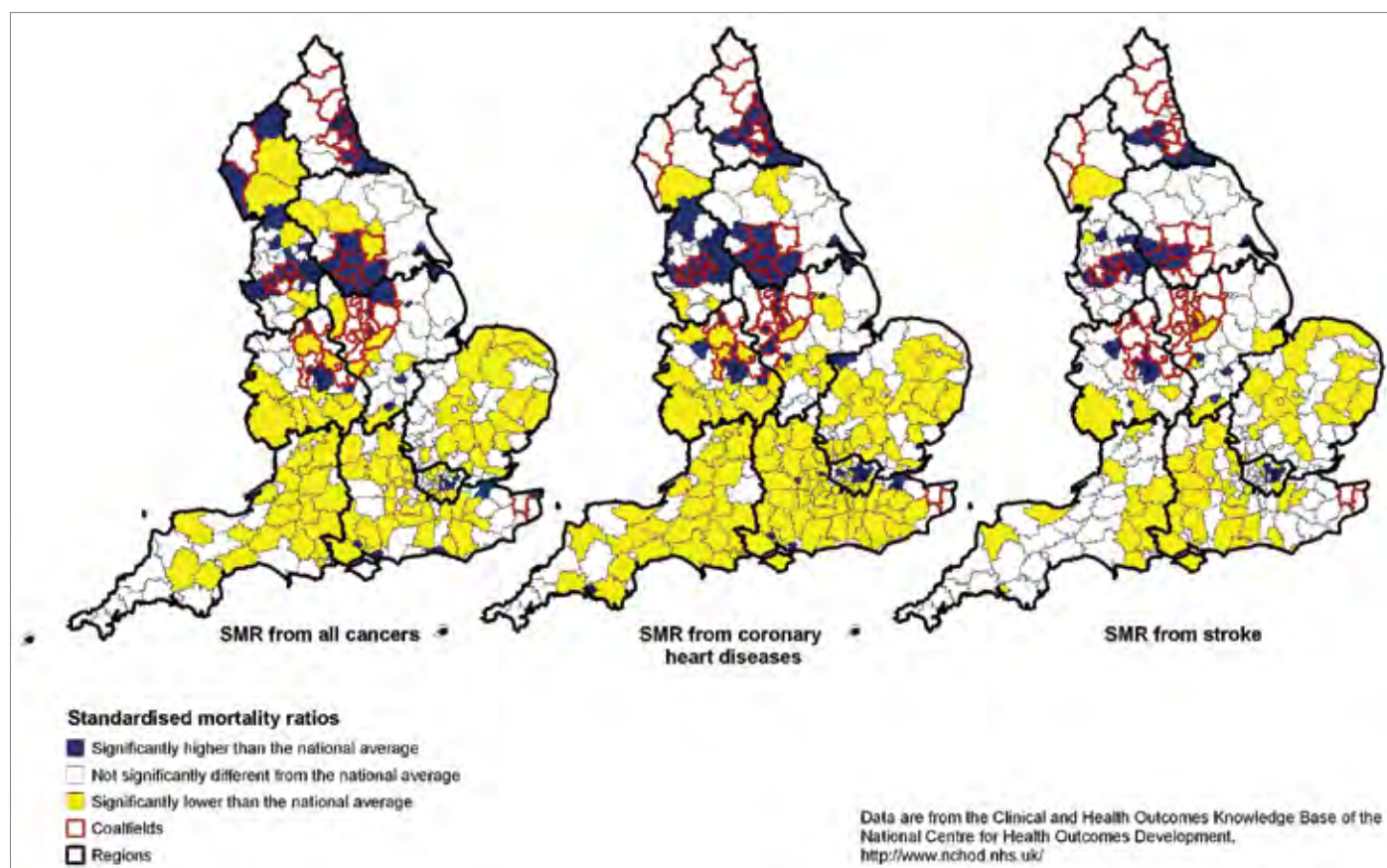


Figure 11: Standardised mortality ratios for persons aged under 75 years (2005–2007)







Therefore though health overall is improving, most of the former coalfield areas are still characterised by less favourable health outcomes and indicators than in the country as a whole. In addition, people living in these areas have a lower life expectancy than in other LA areas in England.

### Comparisons between coalfield areas

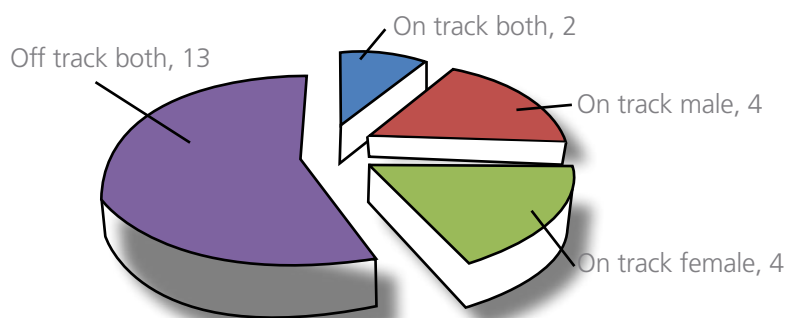
Curiously, mortality ratios in ex-coalfield areas located in rural and coastal settings are significantly higher in comparison to the national average and in comparison to urban and land-locked coalfields respectively. These results seem to differ from studies showing that health in rural areas is often better than in urban areas (Commission for Rural Communities, 2008). But the results are in line with some other studies (see note 7) which report geographic inequalities in health between rural areas, indicating that it is not wise to assume that health in the countryside is universally better or worse than the national average. It's also possible that the socio-economic profile of the population differs between rural coalfield areas and other rural areas, and this might influence the health status described here. Future studies should aim to disentangle these health inequalities in former coalfield areas which are located in very diverse geographical settings.

Coalfield areas that are part of the Spearhead programmes are characterised by higher mortality ratios. This is only to be expected, given that Spearhead designation is only given to the areas which are the most deprived. In addition most are not on track to achieve their health inequality targets (figure 12).

### Section B summary: progress on health inequalities

- A new government in 1997 saw the start of a determined attempt to introduce policy to tackle inequalities. Policies have varied in their ability to achieve their goals and evaluation of them has not always been easy
- Recent and current attempts to review a decade of activity on health inequalities may help us get to the root of what our next steps should be
- Health in former coalfield areas has improved during this period on a number of measures, but corresponding improvements in the health of the general population have seen the inequalities gap widen and the target shift
- There is considerable variability between coalfield areas in terms of their response to regeneration activity, but deprivation levels continue to be higher in coalfield areas than the average for the rest of the country
- Former coalfield areas as a whole are doing significantly worse than other districts of England on health indicators in the analysis undertaken here
- However, comparisons within the coalfield group show interesting variations that could be explored further. Urban coalfields, for instance, have fared worse than rural and coastal areas in terms of economic activity, yet conversely health outcomes are worse in rural coalfield areas.

**Figure 12 – Former coalfield Spearhead areas achieving health inequality target**



Source: Department of Health (2008)  
Tackling Health Inequalities: 2007  
Status Report on the Programme for Action

## Section C

### Working locally for health

In this section we look at ways in which LAs can start to approach this challenge of working for health. We look first at the types of programmes that have been put in place and then at some of the new engines and levers for change being put in place by national level policy to support local level activity. A short section then focuses on the support role of the IDeA in this process before we examine a series of short case studies of local areas in action and the lessons learned from them.

#### Programmes, tools and levers

Though many health targets reside with the PCT, LAs have been taking a growing role in promoting and producing health. As mentioned previously, a range of national initiatives have focused on reducing health inequalities and have done this through routes and by mechanisms in which LAs were major players. While not all of these initiatives were subject to in-depth evaluation they do highlight useful learning points for similar future work.

The Health Action Zone (HAZ) programme, launched in 1997, pushed health inequalities as a priority up the local agenda, although HAZs did not survive long enough to impact on indicators of population health or health inequalities (Health Development Agency, 2004). A key lesson from the HAZ experience may be that there is no single blueprint for addressing complex causes of health inequalities at a local level. HAZs also showed themselves to be capable, in some instances at least, of pointing the way to the development of Local Strategic Partnerships (LSPs).

Another example relates to the early years - often emphasised as a critical period for efforts to tackle health inequalities. The Sure Start programme has placed these years at the heart of the health inequalities agenda. The scheme aimed to tackle the legacy of multiple disadvantage, not least by increasing access to health services. This is done by engaging with families who, traditionally, have been unwilling or unable to take up services, delivering them in a way that better meets their needs. Medium term outcomes are evident, such as reductions in emergency hospitalisations for 0-3 year olds for severe injury or respiratory infection, and increases in health screening and uptake of immunisation (Melhuish and colleagues, 2008). Longer term outcomes may take some while to appear (Barnes and colleagues,

2007), as experience from programmes in other countries demonstrates. The impact of the move from Sure Start to Children's Centres is yet to be seen.

The Audit Commission Report (2008) highlighted the role of LAs in tackling deep seated health and social problems and urged that they and the PCTs should be shifting towards addressing the 'upstream' and complex social issues such as worklessness, low educational attainment and poor housing, as well as the 'downstream' consequences of poor public health. The Communities for Health programme, which provides funding directly to LAs to reduce health inequalities, helps to demonstrate the breadth of the contribution councils can make to creating healthier communities.

Many measures are now in place to align the objectives of PCTs and LAs towards tackling health inequalities and to promote joined-up working. The **Our Health, Our Care, Our Say** (2006) White Paper recommended joint Director of Public Health (DPH) appointments between PCTs and LAs as best practice, and these are now in place in most areas across England. A recent study funded by the Economic and Social Research Council (Blackman and colleagues, 2009) found the majority of people described the role as valuable, but robust evaluation of their impact is not yet available (Hunter, 2008).

In the meantime it is clear that such joint roles present considerable challenges. For a new DPH with a joint appointment, working across two complex and culturally different organisations can be a hard task which demands that the postholder possesses considerable personal qualities of political sensitivity, as well as good communication, strong negotiating, influencing and leadership skills, and a not inconsiderable measure of emotional intelligence (Hunter, 2008).

Along with these posts a number of levers have been put in place to try to achieve more effective working such as local area agreements (LAAs), joint strategic needs assessments (JSNAs) and the comprehensive area assessment (CAA).

Following the publication of the Local Government and Public Involvement in Health Act 2007, local government and PCTs have a statutory requirement to undertake JSNAs. In their new roles, directors of public health (DsPH) work in partnership with the director of adult social services and the director of children's services to undertake JSNAs, in order to establish the current and future health and wellbeing needs of the population, and set in motion plans to tackle inequalities, with a specific focus on age, ethnicity, disability, gender, religion and migrant populations.



The CAAs will build on the Comprehensive Performance Assessment (CPA) that, from 2005, assessed the performance of LAs in improving the health of their communities and reducing health inequalities. The CAA goes further than the CPA ever did in looking at performance on an area-wide basis, thereby including all agencies working together in that patch. It is a 'whole systems' approach that seeks to move beyond the vertically silo-driven approach of the CPA. It is also driven not from the top-down but from the bottom-up. It remains to be seen how successful it will be but the approach being adopted is encouraging.

This is seen as critical in persuading LAs to work with PCTs and other partners on health issues. The large number of health and well-being priorities selected by LSPs in their LAAs for 2008-2011 is a strong indication of partners' commitment to tackling health inequalities and public health issues jointly. In all, 86 LSPs (57 per cent of LSPs) chose to focus on 'all age all cause mortality', 122 (81 per cent) on childhood obesity, 89 (59 per cent) on smoking, and 106 on under-18 conception rate (71 per cent). All these indicators are in the 12 most popular priorities chosen by LSPs. However, national indicators currently focus on the treatment of illness rather than its prevention. The emphasis could be changed at a national level, or this could be an opportunity for local government to develop tailored prevention focused indicators. A long-term evaluation of LAAs and LSPs is being undertaken by a consortia led by Warwick Business School which aims to clarify the effectiveness of current policies.

DH's Programme for Action to meet the health inequalities target (DH, 2007) emphasises the fact that there will be no 'one size fits all' solution to health inequalities problems. It is clear on the need for local solutions to local problems, but also that such solutions must work across institutional boundaries. 'Local solutions' is not code for a 'free-for-all', however. The document is clear about the general template for action, building a case on an evidence base about what has been seen to work and be effective and efficient, but calling for local areas to implement these ideas imaginatively in their own setting.

Therefore actions identified as likely to have the greatest impact over the long term are:

- improvements in early years support for children and families
- improved social housing and reduced fuel poverty among vulnerable populations
- improved educational attainment and skills development among disadvantaged populations

- improved access to public services in disadvantaged communities in urban and rural areas
- reduced unemployment, and improved income among the poorest

Specific interventions directly related to health and seen as most likely to contribute to closing the life expectancy gap are:

- reducing smoking in manual social groups
- preventing and managing other risks for coronary heart disease and cancer such as poor diet and obesity, physical inactivity and hypertension through effective primary care and public health interventions, especially targeting the over-50s
- improving housing quality by tackling cold and damp, and reducing accidents at home and on the road.

To close the gap in infant mortality, key short-term interventions include:

- improving the quality and accessibility of antenatal care and early years support in disadvantaged areas
- reducing smoking and improving nutrition in pregnancy and early years
- preventing teenage pregnancy and supporting teenage parents
- improving housing conditions for children in disadvantaged areas.

These themes are underpinned by five discrete principles that should guide how health inequalities are tackled in practice:

- preventing health inequalities getting worse by reducing exposure to risks and addressing the underlying causes of ill health
- working through the mainstream by making services more responsive to the needs of disadvantaged populations
- targeting specific interventions through new ways of meeting need, particularly in areas resistant to change
- supporting action from the centre by clear policies effectively managed
- delivering at a local level and meeting national standards through diversity of provision.

As the DH website explains the programme 'encompasses local solutions for local health inequality problems given that local planners, front line staff and communities know best what their problems are, and how to deal with them', but tries to embed what they hope will be local innovation and response within a framework that respects the evidence for 'what works'.



‘what works’.

LAs may have key roles to play not just in identifying and remedying some of the more upstream causes of poor health (such as inadequate housing, fuel poverty, inadequate benefit take-up) but also in helping the NHS be clearer about identifying need in the poorest communities, in re-gearing the service offered in ways which are more appealing and which increase the likelihood of service uptake around screening, immunisation and early treatment, as well as in relation to smoking cessation and other issues.

## The IDeA’s support role

Since 2006, the IDeA has been commissioned to work with LAs and their partners to develop capacity to tackle health inequalities and to support local partnership working. Funded by DH and managed by the IDeA, the Healthy Communities Programme aims to build the capacity of LAs working within their communities to:

- tackle local health inequalities
- provide leadership to promote wellbeing
- foster a joined-up approach to health improvement across local government itself and through LSPs and LAAs.

Convinced that the situation in the coalfields was not uniformly bleak, the Healthy Communities Programme organised a round table event in January 2009. This was in partnership with the Alliance (now the Industrial Communities Alliance), an organisation representing LAs in the traditional industrial areas of England, Scotland and Wales. The round table event invited representatives from former coalfield and industrial areas to consider how to:

- better understand the similarities between their area’s health inequalities and the inequalities of others
- enable the IDeA and Alliance to plan future activities with coalfield and industrial councils to help them tackle health inequalities

From that discussion, from previous research work (Bennett and colleagues, 2000) and from evidence gathered through IDeA’s work up and down the country, it has become clear that there are large local variations in the outcomes of post-industrial regeneration in ex-coalfield and industrial areas across the UK, with some areas being more resilient in the face of adversity and with better than expected mortality rates. As a result there was a need identified to examine local conditions and community level actions and

to identify examples of good practice and the way they might contribute to reducing health inequalities.

## Local case studies

Initial conversations with the Department of Health Inequalities National Support Team (HINST) and other colleagues enabled the identification of areas of good practice. Other suggestions came from colleagues engaged in fieldwork on health inequalities and partnership working in LAs.

In choosing case studies we sought to include a wide range of type of coalfield areas across England. We spoke with representatives of coastal and rural areas as well as more urban and traditionally industrial areas. We also spoke with a representative from South Wales whose experience seemed relevant. Nine case studies are presented in this report. Characteristics of the areas selected are shown in table 1.



**Table 1 - Case study characteristics**

Name	Classification	Spearhead area	Recent Beacon Awards	Political Control	Population Mid 2005 (in thousands)
<b>Cannock Chase</b>	Rural		Transforming the delivery of services through partnerships (round seven)  Healthy communities (round six)	No Overall Control	93.2
<b>Derwentside</b>	Rural		Reducing health inequalities (round nine)  Positive youth engagement in the community and the democratic process (round seven)  Supporting new businesses (round six)	Now part of Durham County Council – Labour	86.3
<b>Doncaster</b>	Rural			Labour	289.6
<b>Easington</b>	Rural, Coastal			Now part of Durham County Council – Labour	93.3
<b>Rotherham</b>	Urban		Better outcomes for people and places (round 10)  Better public places (round nine)  Emergency planning (round eight)  Valuing people (round seven)  Delivering of quality services through procurement (round seven)  Supporting new businesses (round six)  Asset management (round six)	Labour	253.2

**Table 1 - Case study characteristics (continued)**

Name	Classification	Spearhead area	Recent Beacon Awards	Political Control	Population Mid 2005 (in thousands)
<b>St. Helen's</b>	Urban			No Overall Control	176.3
<b>Staffordshire Moorlands</b>	Rural		<ul style="list-style-type: none"> <li>• Digital inclusion: tackling exclusion and promoting life chances (round 10)</li> <li>• Transforming services: citizen engagement and empowerment (round nine)</li> <li>• Transforming the delivery of services through partnerships (round seven)</li> <li>• Delivery of quality services through procurement (round seven)</li> </ul>	Conservative	94.6
<b>Stoke-on-Trent</b>	Urban		<ul style="list-style-type: none"> <li>• Transforming the delivery of services through partnerships (round seven)</li> </ul>	No Overall Control	238.3
<b>Wales Heads of the Valley</b>	Rural		N/A		



In each area a number of key stakeholders were invited to take part in telephone interviews and the information given was then used to draw up a short report on activity in that area. Inclusion as a case study is clearly no guarantee that the practices described are effective – in many cases the measures described are relatively new, unproven and have not been evaluated. By the same token it is clear that there will be many examples of similar practices taking place elsewhere and many other instances that we cannot report. Those included are merely indicative of the range of activity being undertaken in coalfield areas with the aim of improving health and lessening inequalities. However they are designed to inspire your own work locally and hopefully provide a useful stimulus for local debate or action.

## Cannock Chase

Cannock Chase is a rural area in the West Midlands with some innovative ideas for using partnership working to tackle the health of the most disadvantaged and vulnerable.

The 'Health Net' project, piloted by the neighbourhood empowerment team over the past 4 years and mainstreamed in April 2009, represents a collaboration of three organisations – the PCT, and health and social services departments in the county council and the district council. The project works with the most vulnerable people (approximately 100 families per year), receiving referrals from a range of partner organisations including police, schools and GPs. Four project workers and an information officer work with those coping with, for example, homelessness, child protection issues or debt. Workers discuss issues with the family and agree on a multi-agency plan that the information officer organises. Staff of the Health Net scheme have rapid access to various services and support the family to reach the appropriate ones. Families are typically part of the Health Net scheme for one to two years and are then 'weaned' off the service to limit over dependence. Jonathan Bletcher, head of district partnerships at South Staffordshire PCT explained that with the services of Health Net they are not

"trying to change the system but rather to work within the system [...] the family may not know how to fill in a form or how to present their case in its entirety".

Another interesting approach in Cannock Chase focuses on 'arts, health and wellbeing', a strategy adopted to reach people with barriers to living a healthier lifestyle, such as low motivation, low literacy, or lack of money etc. Cannock Chase Council approached the PCT over eight years ago to develop a pilot project and secured a small amount of Lottery funding. Many others have taken place since. The latest includes a production of a book entitled 'The Good Life' which acts as a local tool to inspire 'fun ways to family health'. This collaborative initiative with various council departments, the PCT, local families and a wealth of other organisations, is currently being developed into an interactive website.

The arts focus has also allowed a participatory approach to health issues. Arts development officer Lisa Shephard, who works for Cannock Chase Council, comments:

"The PCT identifies both the issue and relevant target group. My role is to try to develop local creative initiatives with appropriate organisations

that will truly engage the community.

“Most importantly we aim for those organisations to gain ownership, by shaping art-based projects that help them meet their objectives. It’s about finding common ground among all the partners.”

According to Lisa, the net result is that

“people are starting to see that they can work more creatively in achieving health objectives and in the way that they communicate with their clients.”

### Key messages:

- Intensive support for the most disadvantaged families may be necessary to help them navigate their way through complex services and systems.
- The use of art in health provides access to people who may have low literacy levels.
- Approaches using art have also been used to encourage more participatory approaches in health projects and have helped increase the ‘buy in’ of partner agencies.

## Derwentside

Derwentside is a semi-rural area in the north east of England, and is one of only two Spearheads outside of London on course to achieve the target reduction in health inequalities for both men and women. In the 1980s, with the closure of the steel works following the final closure of the coalfield, 35 per cent of the working age population were unemployed. In April 2009, Derwentside local authority became part of Durham County Council.

The depth and scale of the problem led to the authority taking the lead role in establishing partnerships to secure investment to regenerate the district with modern factory and office developments, major investments into public housing (40 per cent of the district’s homes), a major programme of IT infrastructure development, as well as significant expenditure in developing community engagement.

However there remain pockets where people can be classified as third-generation unemployed, with the health inequalities that accompany this statistic. In addition to the health legacy of its industrial past this meant there was more work to be done to impact directly on health.

According to Iain Miller, public health partnership and performance manager for NHS County Durham and NHS Darlington public health team:

“Recent history has galvanised this place to realise that it could not do things on its own”. Health services had to join forces with the local authority if they were to have any chance of making a difference. As Iain stated, ‘it came from the top’, with one of the very earliest appointments of a joint director of public health. Iain explained that the partnership was so strong that “everything went through both boards’. He went on to say that “you cannot overestimate how having that weight behind a subject allows health to be seen as a priority.”

All areas of local authority activity became involved in promoting the health agenda. One example is that Derwentside had gone smoke-free prior to the national smoke free legislation. The LA and PCT, working in conjunction, were able to extend the smoke-free areas to include play parks, thus stopping people smoking around children.

Education is another upstream area of joint activity. In Stanley, one of the most deprived areas, a project began



five years ago called Aspirations Begin at Home. Home computers and broadband were provided to two cohorts of children to enable them to improve their education, and classes were offered to encourage parents to become computer literate and increase their involvement with their children's education. The focus of the project was not only educational but also aimed to improve adult socialisation through encouraging access to information and online services, including those relating to health.

In order to reduce the number of incapacity benefit (IB) claimants, the PCT, Job Centre Plus and the economic development department of the local authority created an employment team tasked with supporting IB claimants back into work. One of the biggest barriers to re-employment is around mental health and so the team includes two mental health workers.

Partnership working extends beyond statutory agencies. A current example is the relocation of allotments from land that has been earmarked for redevelopment. The new allotments will have an educational element with school children encouraged to grow their own fruit and vegetables, and will be run by the voluntary sector with the support of schools, a housing association and a local supermarket.

Kevin Earley, healthy policy officer at County Durham, put it quite plainly:

"One of the things about health is that it is very difficult to be against. Because of the wide determinants of health, everything you do fits into someone else's agenda. Improving education or employment also improves health outcomes. Health is not party political or divisive, because health is important to all – you haven't got anything if you haven't got your health."

## Key messages:

- Strong, consistent strategic leadership of key agencies makes a profound difference to the quality of partnership working.
- All departments of local authorities can contribute to health improvement agendas.
- Having the local authority on board allows the upstream approaches to health that have begun to turn around the health inequality figures.

## Doncaster

Doncaster is a Spearhead area in which distribution and call centres have replaced old coalfield industries. It is on target to reduce health inequalities for women, a success which may stem from a consistent approach to the problem despite the organisational changes of the past 10 years.

But Dr Rupert Suckling, deputy director of public health at NHS Doncaster, was in no doubt that rates of mortality and morbidity were directly linked to the previous industrial past.

"We have higher rates of lung cancer, respiratory disease, high rates of stomach cancer related to mining, and lots of people on IB following industrial changes in the early eighties," he said. The reason the same achievements cannot be claimed for men's health, he feels, is that men are less likely to present early to services, yet they are at higher risk of heart disease and lung cancer.

The PCT therefore commissioned researchers to speak with people who had been successfully treated for lung cancer. Was there anything else that could be done to get people to treatment earlier? A local media campaign subsequently targeted men aged 50-65 in the most deprived communities who had a cough for over three weeks, encouraging them to go to their GP for a chest x-ray. At the same time, PCT representatives ensured GPs were aware of the campaign and responded appropriately. During the trial period the number of x-rays in the pilot area was three times greater than in the rest of the borough. That change translated into potentially saving about 20 lives a year, about a quarter to a third of the excess cancer deaths in Doncaster as compared to the rest of England.

A second major project explored provision of services in the most deprived communities. Formal mapping of needs was accompanied by a realisation that front line staff had a lot of 'local intelligence' that wasn't being used. To harness this, the PCT created 'community conferences' within each of the most deprived areas. Representatives from the LA, schools, police, voluntary organisations, faith groups, GPs, community workers, neighbourhood wardens and others identified what the main issues were, looked at what worked well, identified gaps and prioritised issues. The final reports provide a basis for PCT commissioning, with the intention of shifting services to areas of greatest need. The PCT is now planning to create an annual event to report back to communities on progress in aligning services to needs.

"This has been a big learning curve for us," said Jacqui Wiltschinsky, assistant director of public health. "But it has helped us hone in on what our priorities are and how we work closely with other agencies."

## Key messages:

- \* Getting patients to treatment early saves money and lives.
- Combining 'push and pull' tactics, using media campaigns, service alignment, and community level encouragement may be necessary.
- Tackling the worst health inequalities may mean realigning service provision and location with community needs.

## Easington

Easington is a coastal area in the north east of England with one of the highest rates of deprivation in England. At the start of the 1980s, 53 per cent of all males were employed in mining, so half the workforce was made redundant over an 18 month period. Easington local authority became part of Durham County Council in April 2009.

Over the decades Easington has undergone organisational and boundary changes – both in terms of the local authority and the health service – and these have affected progress. This is a fact acknowledged in a report in the early 1990s by the Regional Health Authority. Recently worries were expressed about how recent changes in both the local authority and the health service, which were designed to create bigger units of administration, will affect work that has started to show improvements in the health of the population of Easington.

One of the issues highlighted was one of needing to tackle 'mindset' in an area where people have adapted to accept the poverty in which they currently live. John Murphy, former LSP manager for East Durham, explained:

"Average wages were higher 25 years ago than they are now. The workers were well remunerated for the difficult and dangerous job that they did, and once that disappeared and the disposable income disappeared it affected local shops so they died as well.

"We now have one of the largest proportions of people on IB, and I understand that GPs were complicit in this, looking at a lot of men saying that they were not likely to work again because of their age and that they were carrying a few knocks. Then they signed them off for life."

John continued to explain that in the past there had been a sort of urban myth which assumed that once the miners had passed away, the high rates of ill health would have decreased. However, looking at the statistics they discovered that this was not the case, as many people on IB are too young to have been ex-miners.

Schemes such as Early Door have been set up to deal with this issue, with the PCT and Job Centre Plus focused on working together to help people on IB overcome health barriers.





"We have worked with Job Centre Plus to design a programme that provides additional health support for people with mental health and musculo-skeletal conditions to help people get back to work," said Graeme Greig, health improvement manager at County Durham PCT.

The mental health of children has also given cause for concern since a study three years ago identified that local six to eleven year olds were four times more likely than the national average to have emotional, behavioural or mental health problems. To address this, a programme has been established in schools involving voluntary and community organisations in providing additional tier 1 and 2 services for children.

"We will see after two years whether there is a big impact as the children become young adults," commented John.

Anna Lynch, director of public health at NHS County Durham and formerly doing the equivalent role at Easington PCT, felt that Easington had made significant progress in many key areas, having one of the country's first (and best performing) smoking cessation service, trialling early versions of CVD screening programmes in the workplace and so on.

The value of partnership working could not be overstated, however, as Graeme pointed out: "From the NHS's point of view we have always recognised that we have a key part to play in improving health, reducing health inequalities and improving access to services. However, the greatest gains will come from working with the county council and other partners on the broader agenda to create jobs, improve education, the environment and reduce crime."

### Key messages:

- A lack of consistency in administration of the area due to boundary changes may have contributed to slowing progress on health improvement.
- Low aspiration and a culture of learning to live with poverty can become as big an enemy to good health as many other negative health behaviours.
- Addressing mental health problems is seen as a key area for health improvement, not just in IB claimants needing to return to work, but also in younger cohorts already feeling the negative effects of poverty and low aspiration.
- Partnership with local councils is seen as key to the progress that has been made on many health fronts.

## Rotherham

Rotherham, originally a coal and steel area, has seen employment grow through regeneration activities over the past decade. These jobs have been across a range of sectors, with a proportion being lower skilled, lower wage jobs. Simeon Leach, economic strategy manager of Rotherham Council, noted that:

"Older workers from traditional industries don't always have the most appropriate skills for taking up these new types of job, so the council and partners have worked together to ensure that support and advice is available to them, often utilising external funding sources to pay for it."

Rotherham has designated Spearhead status and ten years ago was one of the worst areas in the country for heart disease, a legacy of the industrial past. Since then Rotherham has made progress and has achieved a reduction to the national average for this disease. However, Rotherham is still 'off target' for achieving the 2010 health inequalities goal. Because this target is a relative one, Steve Turnbull, partnership manager in Rotherham Council, noted that as fast as they made progress towards meeting it,

"the target moves away".

Steve felt that improvements in single disease problems

"had not been fed back into our life expectancy figures, so effectively people are dying from something else, which just emphasises that progress has to be more about wider determinants of health".

Rotherham has therefore focused on raising awareness of public health within the council. There is an understanding that

"some of the ways in which we need to change people's behaviours and to support them to make that change lie in the hands of the local authority, not the PCT," said Steve.

"Now, whenever we've got a health issue, let's say heart disease or obesity, they understand this may revolve around opportunities for physical exercise or access to food. The PCT can champion it, but at the end of the day a lot of the control is down to the local authority which can have a huge impact on people's health and wellbeing."



The council has created an Officer Network for Health, which enlists members from departments as varied as the library service and transport planning.

A particular focus is work with IB claimants, many of them previously employed in the heavy traditional industries. People on IB for a long time face real difficulties, however.

“It is difficult to come back into work after you have been out of it for such a long time,” says Simeon.

“The current difficulty with the recession is that people who have recently become unemployed look like better employment prospects than people who have been out of work for 12 months plus, and are getting more of the jobs, moving long term IB claimants even further away from employment because of the competition.”

Another strand of work will focus on supporting employers to hire people with health problems. Simeon added:

“We have submitted a funding bid looking at working with employers to help them if they are proposing to take on someone who has underlying health issues. So they don’t think that because X hasn’t worked for 18 months there may be associated problems and they’d rather employ someone easier to manage.”

## Key messages:

- The difficulty of meeting shifting targets for reducing inequalities means it is important to look at all areas of health and not to focus on just one health issue.
- Responsibility for health improvement involves a whole array of people and it is critical to get officer ‘buy in’ from all corners of the LA.
- Work to draw IB claimants back into work needs an approach that supports employers as well as IB claimants themselves.

## St. Helens

St Helens is a small metropolitan area in the North West of England situated between Manchester and Liverpool. Industrial employment in the past was related to coal extraction and glass manufacture. Decline has occurred over a long period as the mines did not all close at the same time, but St Helens is now a designated Spearhead area. St Helens had made a conscious decision to diversify and increase the number of start-up companies. According to Steve Berlyne, St Helens’ funding and economic intelligence manager, they have had

“a significant diversification, and an increase in the business space, but from a very low level.”

They are also trying to increase entrepreneurship as a means of transforming ambition and enterprise.

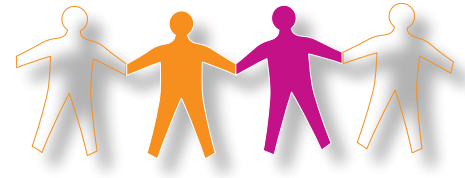
Dympna Edwards, deputy director of public health, felt that a critical element in partnership working was the building of trust between agencies and also the building of trust with local communities

“so that we are a resource for them, rather than doing things to them. Building of trust doesn’t happen overnight”.

A number of examples of cross agency and partnership working can be found in St Helens. The Shoots Food Co-operative is an example of a project that was originally funded and delivered by the PCT but is now delivered by a housing association and is exploring the potential of becoming a social enterprise. The project is a co-operative of 300 people who are part of a tenants’ and residents’ association.

Fruit and vegetables are bought in, often from allotment growers, and brought to a central point where they are packed by people who have been placed on community service orders and are under the supervision of the probation service. The fruit and vegetables are then distributed through the tenants’ and residents’ association, allowing local people to purchase for £2 every week a bag of fruit and vegetables worth £8. Volunteers in the programme get free fruit and vegetables in lieu of their time, as do the people on the community service orders.

Another initiative, which combines a health focus and health resources with community level interventions, is the ‘Cancer Checked’ campaign. In common with many other areas of deprivation with poor health status, cancer survival rates were particularly poor, not least because people approached the health service at a very late stage



in their illness. Using a 'healthier communities' approach, the PCT worked to overcome the taboo of cancer by using community-based health trainers. As a result the number of people who have accessed GP services at earlier stages has gone up dramatically. Dympna feels that the success of this programme is very much down to the information coming from health trainers and community development workers who convey trusted and relevant messages, as well as to a strong social marketing campaign.

Partnership working runs through relationships with a whole range of agencies. Merseyside Fire Service in St Helens, for instance, received Beacon status for their work on health inequalities. The fire service works to direct people to the smoking cessation service when making safety assessments. Another project focuses on child safety, whereby when the fire service attends a home to carry out fire assessments and hand out smoke alarms they also check for child safety equipment and will work collaboratively with health visitors on these assessments.

### Key messages:

- True partnership working may involve the gradual building of trust between professional groups and agencies and also with communities.
- Partnership working between agencies works best where there is joint ownership of each other's agendas.
- The hardest people to reach may be best served by sources of information or access to services brokered by people working at community level.

## Staffordshire Moorlands

At the peak of its prosperity, Staffordshire Moorlands could boast not just a strong coal industry, but also ventures such as the potteries, and steel and textile mills. Because of this variety the issues the area now confronts focus around de-industrialisation more generally, rather than just coalfield decline and closure. At one time the area was a net importer of labour from other industrial and coalfield areas in the UK and Europe. Now approximately half the population travel outside of the area for work in Stoke-on-Trent, Newcastle-under-Lyme, Macclesfield and the neighbouring areas.

Attempts at economic regeneration have brought different types of jobs to the area, but as Councillor Kevin Jackson, from Biddulph East, one of the worst affected areas, notes:

"The old industries were replaced with distribution centres, but these are not necessarily well paid jobs."

The miners who actually dug the coal out were highly skilled people within that sphere, but their skills weren't easily transferable. Councillor Jackson was clear that many men from the coal industry in particular had not worked since being laid off when the industry closed. However, those who worked in the pits on the 'craft side', like the mechanical or electrical engineers, found it easier to transfer their skills to other industries. Lots of regeneration money had been poured into retraining, but

"there weren't the jobs about - the number of actual jobs that accrued from the training provided was negligible".

Many went on to sickness-related benefits rather than unemployment benefit.

The consequences are not hard to find. The first LSP in 2003 identified Biddulph East in particular as a hotspot for antisocial behaviour, poor health, poor community safety, high crime, educational under-attainment and a high degree of worklessness.

The council has not received any additional funding to support work on the health inequalities agenda since they do not have Spearhead status, but decided to learn lessons from the Neighbourhood Renewal and Neighbourhood Management Pathfinders. As a result, four years ago they developed a local multi-agency partnership involving over 30 organisations, together with the local community across Biddulph East, as part of the Local Strategic Partnership.

Mark Forrester, head of communities at Staffordshire Moorland District Council, noted:

“What the LSP did was to focus on the lessons from neighbourhood renewal. We decided to target this area [Biddulph East] in a coordinated way, bringing all of the partners together, involving the local community, and developing a neighbourhood plan and a series of actions to develop the plan.”

Mark continued:

“It was a case of targeting the mainstream funds in a more coordinated way. Anyway, where there are community projects they harness the energy and resources the community itself has.”

A perverse benefit from not having any significant additional funds was, as Mark said, that agencies didn't need to meet to fight over how they would apportion or spend the money. Therefore he added: “

The partnership is about helping each other achieve our objectives and bringing to the table what we've got.”

At the moment they have a significant project at the centre of the main housing estate in East Biddulph. Here, a large playing field previously seen as

“a bit of a green desert”

according to Mark, has become the site for developing physical activity, play activities and a community garden. The project has cost about £200,000 and some of the funding has come from the PCT and the rest from the county council.

## Key messages:

- The absence of specific funding to tackle health inequalities is not in itself a barrier to activity.
- Focused partnership activity can allow agencies to pool their strengths and existing resources to tackle community level projects that have the potential to make a difference to health.

## Stoke-on-Trent

Stoke-on-Trent has an industrial history that included coal, potteries, and steel. With the decline in extractive and manufacturing industry in the UK, Stoke's fortunes have changed. Now a Spearhead area, with 18 out of the 20 wards in the LA lying below the England deprivation average, there are many long term changes which have to be made to address the accompanying health inequalities. As LSP strategic co-ordinator Judy Kurth notes, this includes challenging the planning agenda in terms of its impact on health and obesity, addressing low aspirations, and ultimately encouraging people to become

“co-producers of their own health”.

Stoke has put in place an ambitious plan to drive more rapid improvements in public health. A major challenge in Stoke is the high numbers of people with complex long term health and social problems which impose a burden on primary care both in terms of those patients who are known to practices and those who are yet to be diagnosed. An example is high blood pressure, where about 16 per cent of adults are currently diagnosed as having high blood pressure, while the true level is likely to be well over the 25 per cent national average estimated through the Health Survey for England. As Dr Zafar Iqbal, deputy director of public health notes:

“That means that there are a large number of people who are not on practice registers for other conditions as well, such as diabetes and respiratory disease. It not just identifying people that is the challenge, but also providing optimal structured care.”

He believes that

“primary care can make a strong contribution to health improvement in the short term whilst job creation and improving educational outcomes would take a much longer period of time to address the inequalities gap between Stoke and England,”

Following The 2007 DPH Annual Report, NHS Stoke-on-Trent agreed a new primary care strategy entitled “Creating a community orientated primary care service” with the aim of improving the quality of every single practice as well as tackling inequalities in health outcomes. Over the past 18 months, Dr Iqbal has worked jointly with GP leaders such as Professor Ruth Chambers and Dr Steve Fawcett (Professional Executive Committee Chair) to create a new primary care model that has the ambitious aim of providing some of the



best primary care outcomes in the country. They started by defining outcomes for provision of optimal care for patients with long-term conditions. Secondly, practices were encouraged to focus on unhealthy lifestyles and maximise the impact of primary care on behaviour change. Every practice has been assessed through CHEC\* and is now in the process of developing an 85 point plan to achieve the outcomes over the next three years. A Primary Care Development Unit to support practices to achieve these outcomes has also been established.

Ian Gibson, head of quality and effectiveness at NHS Stoke on Trent is delighted with the speed of progress.

“It is not just a few, but every practice within the area that has plans to achieve some very ambitious outcomes.”

He also praises the strong medical and managerial leadership culture which has enabled this to happen.

[www.chec.org.uk](http://www.chec.org.uk)

## Key messages:

- Long term strategies to achieve fundamental change can be matched by short term attention to service delivery in health at primary care level to achieve some quicker wins for people's health.
- A new primary care strategy focuses on optimal identification and management of people with long-term conditions. It also focuses on supporting behaviour change with an emphasis on self-care and a partnership approach with patients for issues such as smoking, alcohol use, low levels of physical activity and obesity.
- Ambitious goals have been set in the form of outcome targets to be achieved within three years, with all primary care practices signed up to deliver.

## Wales: Heads of the Valley

Heads of the Valley is a partnership of five LAs in South Wales, once a coalfield, but now the most deprived area in Wales. The topography of deep and narrow valleys has meant that communities are isolated from services and it is not easy to travel from one valley to another, especially on public transport.

While most of the mines shut in a relatively short period in the 1960's sixties and 70s, the last mine in South Wales – Tower Colliery near Hirwaun which was owned by the workers themselves – closed in January 2008.

“The legacy is still very raw,”

according to Maria Uren, health improvement co-ordinator for the Heads of the Valley area.

Much previous regeneration activity focused on the physical side of regeneration such as removing the scars of coalmining and building community centres. Heads of the Valley is a long-term strategic regeneration area funded by the Welsh Assembly Government until 2020. The scheme initially also started looking at traditional forms of regeneration, for example upgrading town centres and improving the built environment; any health improvement was seen as a by-product of that effort. However there is a difference of eight to ten years in life expectancy between the Heads of the Valley area and some of the more affluent areas in Wales, and in terms of healthy life expectancy the gap is even higher, at around sixteen years. It has since been realised that it is important to maximise health gain as part of the regeneration programme.

Part of the problem, as Maria explains, was the compartmentalisation of understanding about where health was created and who had responsibility for promoting it.

“Education was just education; they didn't necessarily see how that would impact on health (including mental health), and likewise how someone's health and wellbeing would impact on their educational attainment,” she says.

Now the regeneration programme embraces a social model of health, which includes looking at the wider determinants of health such as housing, transport, education, employment and crime.

The current programme differs from those previously implemented, in that part of the funding comes from each of the LA areas which are required to produce holistic area regeneration plans (HARPs) made up of a number of

projects within their own area. Needs are identified through community consultations and through work with different organisations within communities, or the local authorities and public health teams. Some of the current programmes focus on establishing food co-operatives, walking groups, and allotments. While these might be considered upstream ways of impacting on health, according to Maria they do have a benefit in terms of health inequalities.

Another example is 'Job Match', a programme for people who have been unemployed for a long time. Many people are too depressed and demoralised to go directly into jobs. Maria's role is to encourage them to access community level activities that are perceived as 'low risk' such as cookery classes. This type of engagement can build confidence and self esteem and move people towards behaviour change so that they can then contemplate paid work.

### Key messages:

- Embracing a social model of health has helped redefine the goals of regeneration in this area.
- Health inequalities can now be tackled through a whole range of agencies dealing with housing, transport, education, employment and crime.
- Small-scale locally-defined projects with low threshold access are seen as a way of building confidence among those demoralised by long-term unemployment.



## Are there general lessons that emerge from these short case studies?

It is evident that the problems described to us in many of these settings are complex and that health inequalities are truly a 'wicked' issue - an issue that requires complex solutions based on different public and private services working together, and where we may not always have a clear understanding of the causes and how outcomes can be best achieved (Rittel and Webber, 1973; Blackman and colleagues, 2006). Some areas have clearly embraced partnership working, and where LAs have taken on board their health improvement role, a number of upstream initiatives have taken root. In the best examples, considering the health implications of all types of activity seems to have become embedded in the thinking of the council. In other areas, partnership working seems more tokenistic and fragile, vested perhaps in one or two projects rather than woven into the fabric of mainstream decision-making more generally.

One of the ironies, of course, is that much partnership working is upstream and more likely to affect the health of the next generation of adults rather than the present one. Such long-term thinking is necessary but sits uneasily with a target-driven system which requires the impact of initiatives to be demonstrated quickly. A balance needs to be achieved between measures which are evidence-based and secure quick results which achieve better outcomes for many people who may have died prematurely or require treatment immediately e.g. prescription of statins and coronary vascular diseases (CVD) screening, and those which are more upstream. Measuring the more intangible outcomes of some upstream activities can be a challenge and lead to a focus on quick wins, especially with the 2010 target in mind. The Marmot review, with its focus on evidence, metrics and implementation, seeks to help address this imbalance in future policy.

Former coalfield areas cannot afford to be short-termist, with an eye only on meeting targets quickly. There is still a substantial legacy of illness arising from the particular physical conditions endured in heavy and extractive industry, but more intransigent problems arise from poor mental health. Long term unemployment is not surprisingly associated with high levels of depression and is reflected in many areas by the large numbers of people on Incapacity Benefit. Many of the schemes described are focused on people in receipt of such benefit and involve rebuilding confidence, teaching new skills and reconnecting people to services. The Welsh experience spoke of the value of small-scale locally defined projects with low threshold

access which were seen as a way of building confidence among those demoralised by long term unemployment. Several respondents cited the impact that low aspirations and a 'poverty of ambition' are having on their younger populations too because of the lack of opportunities perceived to exist in many of these areas. Many young people in areas where there are second or third generations of people unemployed were described as disillusioned and are responding by lowering their aspirations.

One of the overarching themes that emerged from these discussions is the importance of partnership working. For some partnerships the embedding period took longer than others. However once the majority of the creases had been ironed out the partnership was able to be larger than the sum of its parts; they were said to be able to have a larger impact on their population than if they worked in isolation on their own. Similarly, it was felt that small pots of money, when pooled, were reported as able to achieve more than they would have done on their own.

Many of the areas that were studied had a DPH who held a joint appointment between the LA and the PCT. Such appointments were generally felt by those interviewed to have been successful. A couple of areas had gone even further by having a health coordinator within the LA. This meant that both organisations had a conduit, a sort of 'translator' who was able to both translate the language or jargon that each organisation used and point to the right person on the ground within the partnering organisation.

Strong strategic leadership was felt to be crucial in efforts to take forward the health improvement agenda. The case studies provided examples of where consistent political and strategic leadership had brought benefits, and where boundary and organisational changes had made the steering of a consistent course extremely difficult.

Another commonly occurring theme was the need to make services needs-led and to work from the community up, rather than from the top down. We were told by many people about communities that did not trust officialdom or statutory services, so that there was very little wonder that people turned up late for medical treatment, already in an advanced state of illness.

Low levels of literacy and difficulties in engaging with agencies because of form-filling, for instance, served as barriers to people accessing services properly. Schemes like those described in Cannock Chase offered intensive support for the most disadvantaged families, which may be necessary to help them navigate their way through complex services and systems. Getting patients to treatment early was clearly



seen as saving money and lives and there was widespread recognition that this issue had to be tackled at both ends. It had to be done both by improving the service offer through redesigned primary care facilities or relocation in areas of deepest need, but also by working at community level with what were described as 'push and pull' tactics, using media campaigns and community level encouragement where necessary. In many areas the value of 'non professional' health trainers or community development workers was seen as a critical bridge to services for the most disadvantaged.

All of those we spoke to were concerned about the impact the recession will have on their area. Worries focused on the impact that the loss of work will have on individuals in terms of stress and mental health, and also on the effect that the loss of earning power will have on the rest of the local economy. Many also worried that they may lose external funding to support their work on reducing health inequalities in their area. Many local areas acted immediately to try to counter or forestall the worst effects of a recession. The websites of the Local Government Association and the IDeA illustrate the range of measures being adopted to meet the recession head on (see note 8). The government measures announced at the end of September 2009 (Coalfields Growth Fund) are efforts to stave off the worst effects of the recession.

Public health spending routed through the NHS is notoriously vulnerable at times of cutbacks, invariably losing out to clinical services, the loss of which (in the form of ward closures or increased waiting times for operations) always makes bigger headlines and attracts public concern. Similarly, as budgets tighten for LAs, a greater focus may be placed on statutory services, and those that contribute to health inequalities / partnership working or the wider determinants of health may suffer as a result.

The people we spoke to felt that they would struggle to take the next step of improvement if funds are cut further. Recessionary times can demand greater spending on the most vulnerable populations. In some areas plans were already afoot to commission extra counselling support for people who will lose their jobs, increased health checks for children who might end up 'going without', and other measures.

One of the greatest fears is around the possibility of a surge in youth unemployment. As Councillor Jackson from Staffordshire Moorland explained:

"Someone who is 19 would cost next to nothing to get rid of, but someone who is in their thirties

or forties with that much more experience, more useful to the company, would cost a lot more to get rid of. I mean young people are quite often an easy target [...] but this will have an impact on the future because you end up with young people with nothing to do. I saw it in the 1980s, and you end up with disillusioned parents who aren't working and who bring up children who are disillusioned, with low aspirations. It is a vicious circle".

Some former coalfield areas were already dealing with high levels of mental ill health in young people and recessionary difficulties are only likely to exacerbate the problem.



## Section C summary: Progress on local working for health

- Tackling health inequalities has been a key part of the government's priorities since 1997, and was enacted from the start in initiatives like Sure Start and the establishment of Health Action Zones.
- The identification of Spearhead status for the most deprived LA areas has also been key to focusing effort and resources.
- More recent policy moves have focused on developing sustainable structures and levers in local areas that will allow implementation of the policy principles established around health inequalities work. For example the appointment of DsPH with joint remits across PCT and LA, the development of JSNAs and latterly, the Comprehensive Area Assessments rolled out in 2009.
- The Programme for Action offers a template or framework for what is likely to be most effective in general terms at achieving a reduction in health inequalities, but leaves the responsibility for innovation and implementation at a local level, acknowledging that there is no 'one size fits all' solution. LAs have a key role – in partnership with PCTs – in taking forward this agenda.
- The IDeA has a specific focus on helping LAs take forward their agenda for reducing health inequalities, particularly through the Healthy Communities programme.
- The small case studies undertaken for this report demonstrate the challenges in trying to meet 2010 targets on inequalities which demand speedy response and action, and taking the more upstream approaches to improving health that sit more comfortably with LA roles and activities.
- A substantial number of the interventions described deal with the need to improve the lot of the most seriously disadvantaged by making contact, tackling their demoralisation and low aspiration and re-engaging them with services in innovative ways.
- Joint DPH posts were said to be working well, although there has been no thorough independent evaluation of them. But links lower down the chain (for example in the form of information officers or link posts) may also be vital to making the links between LA and PCT functions. Managerial and territorial continuity was said to be vital in establishing a clear direction of travel.
- LAs may have a particular role in helping to make services more responsive and needs-led, helping a reorientation of service as commissioning takes hold in PCTs.
- All areas were concerned about the potential impact of the recession on their progress, with particular concerns being expressed about the health of young people.



## Section D

### Key questions, discussion points and suggestions

In this final section we draw together some of the points that have been raised throughout this document from reviewing policy, statistical evidence and information from those working on the ground, and use the summaries to pose a series of questions and discussion points. The section concludes with a series of suggestions. We hope that this section will provide material and impetus for the debate on these topics at a local level, which is still required if we are to advance the agenda for improving health inequalities in former coalfield areas.

### How should we change our thinking about regeneration?

Some LA areas have seen distinct improvements, but the general difficulties experienced in rebuilding sustainable economies in the former coalfield areas mean there are continuing high levels of multiple deprivation and poverty in many areas. Even where new jobs have been created we know that many vacancies have been filled by incomers with more appropriate skills, making it more likely that the least skilled are doubly disadvantaged. Some of the replacement jobs are insecure, offering only 'flexible' contracts or part time working at low skill levels. More evidence is gradually emerging that shows such work environments can be potentially damaging for health (see note 9), though we do not offer evidence for that here. At the population level, areas of high unemployment tend to have worse health, probably through a lack of employment opportunities, as well as a tendency for those jobs that are created to be limited to insecure employment with stressful working conditions and low pay.

#### Key questions:

- Where there are differences in regeneration successes across areas, are these simply the result of different geographies or are there some policies that are more successful than others in rebuilding stricken economies?
- Have new jobs relieved the unemployment and worklessness problems in former coalfield populations or have long time residents been doubly disadvantaged by being passed over?
- Are these new insecure and flexible working types of job better for health than having no job at all?
- What potential is there in the social economy for rebuilding the economic health of former coalfield areas?



## How can we close the health inequalities gap in former coalfield areas?

Persistent poor health in the former coalfield areas is demonstrated both in life (with high levels of dependency on Incapacity Benefit) and in death (with high levels of premature mortality). It is worth emphasising what stands out in the maps - namely that these former coalfield areas are still among the most deprived, and account for the majority of the areas in the country with significantly elevated mortality.

The goal of reducing the health inequalities for both men and women remains hard to achieve for many former coalfield areas since the target moves away from them when their own health improvements are matched or bettered by even greater health improvements in more affluent areas. The temptation to go for 'quick wins' is immense, though this is not to undermine the very real improvements in health that can be achieved through better screening and treatment, and earlier access to services, for example. However, the very evident long-term mental health problems in both older and younger populations in the former coalfield areas speak of a need for more profound and upstream approaches.

The poor health choices of many people living in poverty (excess drinking, smoking, poor nutrition, under-activity and drug use) are also clearly stacking up problems for future years. Working together with communities using engagement and development techniques that recognise people's strengths rather than demonising behaviour seems the most appropriate way to change thinking. However, individuals are unlikely to engage if they see their prospects as limited and the environment as offering little hope. Health and wellbeing needs to be considered holistically through a range of services which impact on health inequalities. More than a little imagination and a lot of multi-agency co-operation are clearly needed to shift communities onto a different plane.

### Key questions:

- What is your health inequalities gap locally, and what strategy is in place to address it?
- How has the whole council and other partners been engaged in upstream activities to tackle deprivation and improve wellbeing?
- What would it take to hit what is a moving target for reducing health inequalities? How can we close the gap when the health of the population as a whole is improving? How can we improve even faster?
- What should be the balance locally between the quick wins (probably delivered by the NHS) and the more upstream, longer term approaches to improving health (in which local government can be a key player)?

## How should we move forward with local partnership working for health?

Faith in the benefits of partnership working and community level intervention is shown in many of the case studies included here. Irrespective of the cause of the difficulties in their area, all those interviewed were clear about the need to involve a range of agencies in providing solutions. Responsibility for health is no longer seen as resting solely with the health service. Health is seen as the responsibility of all organisations and departments, with local government having a particularly significant role. LAs and the NHS are working on complementary issues but each has the capacity to act in different ways. In particular the organisation and remit of local government allows it to work more effectively at community level, a capacity which makes it possible to develop more authentic understanding of local needs and also to identify and mount the types of low threshold interventions which might encourage people to bring problems or concerns forward to the service. The role of elected members is also key in representing populations and area concerns which are local and specific, and forcing agencies generally driven by national targets and policies to tailor these to local needs and respond imaginatively. The range of services which come under the LA remit allow consideration of the much longer term 'upstream' impacts on health and wellbeing that complement the symptoms-focused services supplied through the NHS.

As yet however, most policies and interventions are only poorly evaluated. Partnerships are a means to an end and not an end in themselves and they will only be worth the considerable effort and investment involved if we can demonstrate health improvements as a consequence. Until now, the evidence on whether or not they contribute to improved health outcomes is lacking (Smith and colleagues, 2009).

### Key questions:

- How far have we identified the complementary roles of different agencies in delivering health in our area? Have we got a 'logic model' that will tell us who is delivering what, and will ensure that resources are located in the right place?
- Have all agencies and all departments within them recognised their responsibility for delivering health, and 'health proofing' their actions?
- How well are our joint structures and the machinery of joint working functioning? How can we evaluate whether partnerships work well and are worth the investment of time?



## How can we minimise the extent to which our efforts to improve health are affected by recession?

The current recession, the most severe for 60 years, is having serious adverse effects on the economies of the former coalfield areas. Though this is not surprising, it is important to bear in mind that this is simply the latest in a series of reversals that have undermined attempts to re-build former coalfield economies around new economic activities.

Recession poses a severe threat to progress on meeting health inequalities targets. Future governments will have to manage a general retrenchment in public spending. There would be a particular threat to the coalfield areas if the extent of deprivation weighting in the local funding formulae for both local government and the NHS is seen to be too high (see Asthana, 2009 for discussion of this). This is a risk especially if the former coalfield areas of the Midlands and the North are seen as diverting public funds away from areas in the South which are themselves facing major population pressures on their services. Any major shift in policy or change in funding, as many people we spoke with in the coalfield areas pointed out, would seriously disrupt their long slow progress towards improving the health of some of the most disadvantaged communities.

### Key questions:

- Have we located where the specific risks might lie in terms of our attempts to improve health – have we broken down what might seem like a monumental problem into its smaller constituent parts?
- Are the risks to some population groups bigger than others?
- Have we looked at the learning and experience from other LA areas on ways of meeting recession head on?
- What arguments can we put forward to protect public health related budgets in LAs and the NHS when the pressures on spending increase?

## Suggestions

- LAs in former coalfield areas should be undertaking very careful audits of the impact of regeneration schemes. The creation of new jobs and their uptake can be seen as only partially successful if such jobs are filled by incomers and the net effect is to mask the drift into even further deprivation of a core group of unemployed original residents
- LAs should ensure that physical and economic regeneration in their areas is matched by attention to 'place building' which focuses on the community. This implies attention to building aspirations and community cohesion, as well as ensuring that local populations are re-skilled to meet the demands posed by new industrial opportunities
- The short term wins likely to have an impact on helping meet 2010 inequalities reduction targets are likely to be most easily met by clinical interventions (for example, screening of over 50s for CVD and cancers, and smoking cessation). LAs have a role to play in this by helping PCTs identify better ways of getting clients to services or getting services to clients, and LAs should work with PCTs to see what contribution they can make in this regard
- The longer term health gains are more likely to be achieved by LA actions than PCT actions, for example through improving housing conditions, by reducing risk of accidents through improved prevention services related to fire safety and traffic, and by raising individual aspiration and lifestyle or behaviour choices through educational opportunity. LAs should 'proof' all aspects of their provision, department by department, to ensure that they have in place policies and practices which contribute to this end (for example – using the Health Impact Assessment process).
- Partnership working seems critical to success, but clarity is needed over where and how PCTs and LAs (and other organisations) should come together. Cross-agency planning and working at DPH level may need to be matched by joint posts at other levels. Where these are put in place the results should be properly audited and evaluated to ensure that the effort involved in partnership work results in real gains on the ground.
- Combating shrinking or threatened budgets at a time of recession and increasing need requires LAs to be well briefed and well focused. Clarity over which groups are most at threat and which services are completely essential to the protection of the fates of the most vulnerable (and probably least well represented or vocal) is vital. Prioritisation and a 'logic plan' should be essential first steps in coping with the downturn.



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## Notes

1. The economic activity rate corresponds to the number of people who are in employment or unemployed expressed as a percentage of the working age population (16-64 for men, 16-59 for women) whereas the employment rate corresponds to the number of people who are in employment expressed as a percentage of the working age population (*Guide to Regional and Local Labour Market Statistics*). The economic activity and employment rates for LA districts were obtained for 1994 and 2007 from the Labour Force Survey:  
[www.nomisweb.co.uk/Default.asp](http://www.nomisweb.co.uk/Default.asp)
2. We opted to compare ranks rather than rates because we can expect that the total working age population in LA districts will have changed between 1994 and 2007, and therefore comparing rates without adjusting for this may bias results. In addition, as we are interested in how areas compare to one another, rather than in their 'absolute' levels of economic activity and employment, ranks appeared to be a more relevant variable.
3. The urban and rural classification of coalfield areas is taken from Defra Classification of Local Authority Districts and Unitary Authorities in England:  
[www.defra.gov.uk/rural/ruralstats/rural-definition.htm](http://www.defra.gov.uk/rural/ruralstats/rural-definition.htm)
4. The overall score of deprivation is derived using the combined deprivation ranks for all lower super output areas (LSOAs) included in any one district and weighted by the LSOA population.
5. Claimant counts were calculated as the number of people claiming Job Seekers' Allowance (JSA) and National Insurance Credits at Jobcentre Plus local offices as a proportion of the total working age population resident in an area.
6. Mortality ratios are the ratios of observed deaths to expected deaths from all causes, standardised by age and sex. Data on standardised mortality rates are for the years 2005-2007 and were obtained from the *Clinical and Health Outcomes Knowledge Base* of the National Centre for Health Outcomes Development: [www.nchod.nhs.uk](http://www.nchod.nhs.uk)
7. See for example:  
Levin KA and Leyland AH (2006) *Urban-Rural Inequalities in Ischemic Heart Disease in Scotland, 1981-1999*. American Journal of Public Health, 96:145-51  
  
Riva M, Curtis S, Gauvin L and Fagg J (2009) *Unravelling the extent of inequalities in health across urban and rural areas: Evidence from a national sample in England* Social Science & Medicine 68:654-63.
8. See [www.idea.gov.uk/idk/core/page.do?pagelId=9487751](http://www.idea.gov.uk/idk/core/page.do?pagelId=9487751) for a range of helpful materials.
9. See, for instance, Richard Sennett's seminal book, *The Corrosion of Character: the Personal Consequences of Work in the New Capitalism* (1999, Norton & Co) or more recently Wilkinson and Pickett's review of the evidence in their recent book, *The Spirit Level* (2009, Allen Lane).



## Glossary

CI – confidence interval

CAA – comprehensive area assessment

CVD – coronary vascular diseases

CPA – comprehensive performance assessment

DH – Department of Health

DPH – director of public health

GP – general practitioner

HAZ – Health Action Zone

HES – hospital episode statistics

HINST – Health Inequalities National Support Team

IDeA – Improvement and Development Agency

ISA – Job Seekers' Allowance

JSNA – joint strategic needs assessments

LA – local authority

LAA – local area agreement

LSOAs – lower super outputs areas

LSP – local strategic partnership

NHS – National Health Service

PCT – primary care trust

PSA – public service agreement

SMR – standardised mortality ratio

WHO – World Health Organisation

## Links

Association of Public Health Observatories

[www.apho.org.uk](http://www.apho.org.uk)

Beacon Scheme

[www.beacons.idea.gov.uk](http://www.beacons.idea.gov.uk)

IDeA Healthy Communities resources

[www.idea.gov.uk/health](http://www.idea.gov.uk/health)

Local information is published annually in the

Local Health Profiles for England. [www.apho.org.uk](http://www.apho.org.uk)

Marmot Review

[www.ucl.ac.uk/gheg/marmotreview](http://www.ucl.ac.uk/gheg/marmotreview)

Neighbourhood statistics

[www.neighbourhood.statistics.gov.uk/](http://www.neighbourhood.statistics.gov.uk/)

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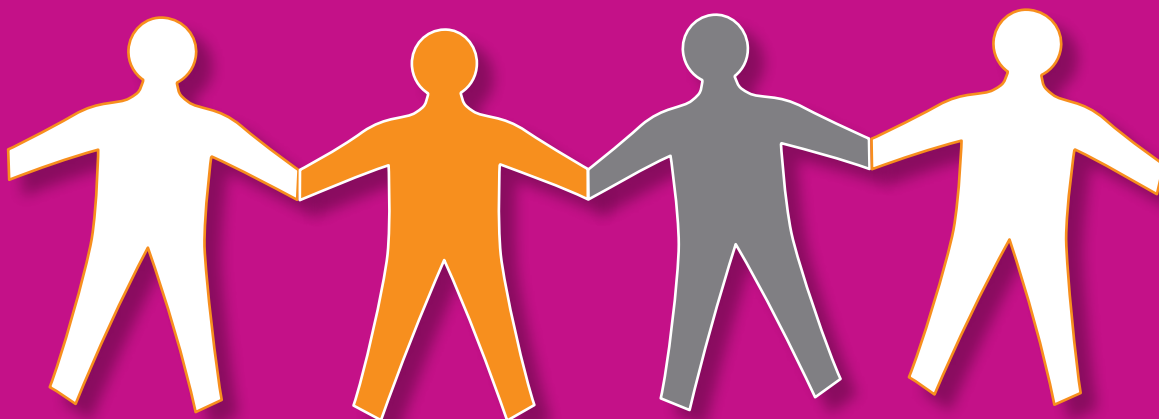
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